A Reform Centred on the Citizen

Gouvernement du Québec
Ministère de la Santé et des Services sociaux

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PREAMBLE

On behalf of the Government of Québec, it gives me great pleasure to introduce the reform of the health and social services system. The National Assembly will shortly be invited to assent to the legislative provisions that will make it possible to adopt the principal measures and initiate the main changes.

We have reached the final stage of a process begun over five years ago. This reform is the result of extensive debate and consultation first made possible by the Rochon Commission Report and, later, by the policy paper of my predecessor, Madame Thérèse Lavoie-Roux. All these efforts, particularly the hearings of the Parliamentary Commission earlier this year, have made it possible to identify the merits and limitations of our health and social services system. Together, we have been able to reaffirm a number of objectives, determine new ones, identify what assets must be protected and decide on the changes to be introduced.

Before announcing the government decisions, I would like to thank all those professionals, administrators of establishments, union members, members of professional corporations, representatives of community organizations, departmental staff and, above all, the users and citizens who, at one time or another, participated in analysing the needs and assessing the solutions to be implemented.

At the conclusion of this consultative process, when the solutions and choices made public today were decided upon, I resolutely adopted the viewpoint of those who expressed a desire to see our health and social services system become more citizen-oriented. The policies and measures that follow have but one goal: to redirect the system towards objectives rather than means, with the focus on the needs, problems and expectations of the individual, in the hope of offering services that can be adapted to these needs with flexibility and rapidity; in short, a system centred on the individual.

I hope that this orientation, which is new in many respects, will result in a new way of thinking at every level of the system, thus giving the builders of the health and social services system greater satisfaction and professional pride while at the same time giving Quebecers a network of health and social services that they can rely on for quality and an effective answer to their needs.

Marc-Yvan Côté
Minister

Québec City, December 7, 1990

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Québec has made great strides in the fight against disease and suffering in the past 20 years. Quebecers are now living longer than before, mainly because of a reduction in perinatal deaths, motor vehicle accidents and deaths associated with cardiovascular diseases and certain forms of cancer. This increased life expectancy may also be attributed to the fact that Quebecers have adopted a healthier way of life. Quebecers in general have acquired better eating habits, engage in more physical activity, smoke less and are now more aware of the dangers of alcohol.

Progress has also been made with respect to social problems. More visible than before, these problems have given rise to new approaches directed at better identifying causes and finding solutions. More attention is being focused on the conditions which bring about problems, leave persons vulnerable and compromise their well-being. Social services are no longer reserved only to individuals who find themselves in extreme situations of marginality or indigence. Individuals grappling with social problems can now obtain assistance more easily, without being excluded from life in society.

So, why reform the health and social services system?

1. THE REASON FOR REFORM

Social and economic changes in Québec have imposed new demands that cannot be met by the health and social services system with its existing means of development, financing and operation.

Pressure will continue to be exerted for additional health and social services. The aging of the population is one of the trends that will have the greatest impact on the demand for services. Radical changes in the family will cause certain health and welfare problems to escalate, calling into question the traditional role the family plays in socialization. These changes will also weaken the role of the family as an important unit of support, forcing its members to turn to the health and social services system for assistance. New problems are also emerging such as AIDS, violence, homelessness and family conflicts. People's expectations are also becoming more varied, as is reflected in the greater awareness of health promotion, prevention and even alternative therapies. Finally, technological development is likely to accelerate.

On the other hand, ever-increasing pressure will be applied to slow down, if not actually halt, the growing costs incurred to meet the needs of the public. Such pressure is already resulting in changes in current mechanisms of financing to bring these growing costs into line with Québec's ability to pay. This pressure becomes all the more significant with the federal government's substantial spending cuts in the area of health and social services. Some are

now talking about charging user fees, setting a price on services and withdrawing from insurance programs.

There will also be pressure to change the ways the health and social services network traditionally responds to needs, with a view to guaranteeing the most efficient use of resources. This pressure raises questions about the very way the network operates. Reference is often made to the fact that too strong an emphasis is placed on institutional, curative and technological aspects. Questions are also raised with regard to compensation for services provided and budget setting for health care establishments which promote the proliferation of services and the development of increasingly sophisticated services. Centralization, bureaucratization and the rigidity of the system have been cited as factors that prevent the health and social services network from adapting to changing needs, resources and communities. The lack of control over public funds is underscored, along with the possibility that funding may at times be misused. Duplication of services and lack of complementarity among the network's establishments are also deplored.

In short, the health and social services system is at a crossroads. Choices must be made to coordinate and make compatible the development, operation and financing processes that characterize the network.

2. THE CHALLENGES OF REFORM

In this context, the reform of health and social services must meet three challenges at the same time:

- ensuring development that corrects present deficiencies in the services offered to the public and that will make it possible to meet future needs;

- ensuring a method of operation that makes the health and social services network more efficient in the use of resources and more effective in solving problems of health and well-being;

- ensuring financing that maintains the right balance between the network's expenditures and the community's ability to pay.

3. THE OBJECTIVE OF REFORM

Although the challenges are clear and agreed on by all, there are major differences in the ways proposed to deal with them. These differences lie mainly in how the solution process is approached. And solutions vary widely

depending on whether the point of view of the citizens, the service providers or the government authorities is adopted.

Quebecers attach a great deal of importance to universal, free-of-charge access to health and social services. In general, people are satisfied with the quality of the services they receive.

Nevertheless, problems do exist: waiting lists, the lack of information on available services or resources, the absence of specialists in remote regions, the lack of rehabilitation resources. Citizens who are affected by these deficiencies have trouble accepting the consequences. The public also demands services that are more humane, more personalized. Some citizens have the feeling at times that their needs or even their rights are given very little consideration.

The solutions generally put forward call on the government to invest more resources, or on health and social services establishments, professionals and employees to do more with the existing resources.

Administrators, professionals, institutional staff and community organizations share the public's viewpoint concerning the value of our health and social services system. Furthermore, they are all proud of their contributions, the quality of the services they offer and their competence.

On the other hand, many feel that their roles, their expertise and their contributions are not adequately recognized. In addition, many also criticize the rigidity of the system, which they feel imposes a plethora of laws, regulations, directives and collective agreements that prevent them from performing their roles effectively.

Health and social services staff affirm, however, that the whole system, particularly their own activity sectors, is underfinanced. Lack of funding is therefore cited as the reason for the lack of beds, the absence of certain services or the obsolescence of the equipment and buildings.

The solutions proposed require either that taxpayers demand less from the health and social services system or that the government invest more in it. Although it is sometimes admitted within the network that savings could be achieved, those who say this always point to another sector, never their own.

Government authorities feel that the current system, which has been in existence for 20 years now, has removed the main financial obstacles that could hinder access to services. Public financing of the system, combined with the progressive character of Québec's income tax system, has brought about a more equitable redistribution of risks. Public funding has ultimately

allowed for better control of the overall costs, certainly much better than in countries where the system centres on private insurance.

Yet, government authorities feel that Québec's system is expensive in view of the portion of the public coffers that must be allotted to it. In addition, over the past ten years the costs associated with the system have grown more rapidly than the government's revenues. Thus, the portion of the budget that the State allocates for health and social services has continued to increase. The situation is made even more complicated by the substantial cuts in federal transfer payments. This trend now poses a threat to the government's budgetary objectives.

Government authorities consider that the solutions call into question both the excessive expectations of citizens with regard to the government and the network and current financing mechanisms which provide neither the citizens nor the service providers with an explanation of their costs. Government authorities also turn to the network to increase efficiency in using the resources earmarked for the sector.

Although these various viewpoints show a consensus on the system's merits and the difficulties it faces, it is undoubtedly more difficult to agree on solutions.

The Minister of Health and Social Services has resolutely adopted the citizen's viewpoint to establish the type of reform that will allow the network to meet the three challenges it faces.

This choice is based on the following reasons:

- the services provided by the health and social services network are intended for citizens;
- it is citizens who pay, either directly or through taxes, for the services provided by the network;
- it is therefore the citizens who must influence the network's orientations.

The fundamental objective of reform is therefore to make the citizen the FOCUS of the health and social services network, with the citizen seen as:

- **consumer;**
- **decision-maker;**
- **payer.**

4. ORIENTATIONS OF THE REFORM

To make the citizen the focus of the network, nine orientations have been chosen.

For the citizen as consumer:

1. Citizens whose rights are recognized and respected;
2. Citizens who benefit from services adapted to their needs;
3. Citizens who receive services as close as possible to where they live;
4. Citizens who are welcomed, assisted and treated by staff dedicated to their task.

For the citizen as decision-maker:

5. Decision-making as close as possible to the action;
6. Citizens at the centre of the decision-making process;
7. Citizens accountable for their decisions.

For the citizen as payer:

8. Citizens who get their money's worth;
9. Citizens who must assume the cost of the services.

The measures adopted entail profound changes to the organization and operation of the health and social services system. They modify the role and position of certain actors as well as the current rules of the game. These measures nevertheless serve a sole objective, specifically, to make citizens the primary focus of the daily activities of the health and social services establishments and of government authorities.

I. THE CITIZEN AS CONSUMER

The health and social services system is having difficulty adapting to the changing needs of citizens. That is the conclusion arrived at on the basis of the findings of the Rochon Commission, the regional tours conducted by the former Minister of Health and Social Services, Madame Thérèse Lavoie-Roux, and the parliamentary commission that met following the tabling of the draft bill respecting health and social services.

The difficulties of the system are of several types, namely adapting to emerging problems and new clienteles; bringing the network closer to citizens in their home communities; adopting new types of measures; and viewing citizens in terms of the whole person and the dignity of the individual. In some sectors, the adaptation difficulties stem from a shortage of resources; in others, they seem to be linked more to attitudes, behaviour and values and, possibly, prevailing corporate interests.

To make citizens the focus of the health and social services system, four orientations have been chosen:

- citizens whose rights are recognized and respected;
- citizens who benefit from services adapted to their needs;
- citizens who receive services as close as possible to where they live;
- citizens welcomed, assisted and treated by staff dedicated to their task.

1. CITIZENS WHOSE RIGHTS ARE RECOGNIZED AND RESPECTED

Every citizen enjoys rights relating to all aspects of life in society as set out in the Charter of Human Rights and Freedoms and various laws of Québec. The current *Act respecting health services and social services* identifies a number of specific rights enjoyed by users in the health and social services sector, namely the right to services and the right to consent to medical care.

However, these users often find that there is a discrepancy between stated rights and their day-to-day application in the network. For example, they wonder what has happened to their right to services when establishments close beds. They are less and less willing to accept being treated without any regard for their values or culture and being deprived of privacy. They sometimes feel that there is a reluctance to provide them with complete information concerning their problems and the choice of treatment available to them.

All these examples show that it is often difficult for users of health and social services to obtain respect for rights as fundamental as the right to information or the right to refuse to be kept alive by artificial means. For many users, the rights conferred by the different charters and laws remain obscure. They have insufficient or inaccurate information on the real extent of these rights and consequently cannot exercise them easily.

That is not all, however. Even when they try to exercise their rights, they often run up against attitudes and practices that have developed more in keeping with producing services than with meeting users' needs. Despite the good intentions of the staff,

users sometimes feel more like passive recipients of treatment or intervention than active participants in their recovery or rehabilitation. In this sense, their rights as individual persons are not being respected.

Nonetheless, few users take advantage of the remedies and complaint processing mechanisms established both within and outside the network. Although many different types of recourse are available, users are unfamiliar with them. Nearly two-thirds of the public have never heard about professional associations and are consequently unaware of the recourse they offer. Users often do not know how to formulate complaints, nor whom to refer them to. In addition, they are reluctant to use the mechanisms established for that purpose either by the network or professional associations, since they consider them of dubious value and ineffective. In fact, two out of every five people believe that the associations strive to protect their members' interests. Only one out of every five persons questioned believes that professional associations have a role to play in protecting the public. In short, users have the impression that the mechanisms established for them operate without them.

In order to ensure that users' rights are recognized and respected, it is necessary to:

- reinforce and expand the rights of users;
- reinforce assistance and companion service mechanisms;
- make the complaint processing mechanisms clearer, more credible and more effective.

1.1 Reinforcing and expanding users' rights

To reinforce and expand users' rights, the Minister intends to explicitly set out in legislation:

- **the right of all persons to obtain adequate, ongoing and personalized care and services from establishments and professionals in the Québec health and social services network;**
- **the right of all persons to obtain the services of the establishment or professional of their choice, consistent with the individual establishments' mandate and organizational plan, the available resources and the regional organization of services;**
- **the right of all persons to information concerning their state of health and well-being, the care they are receiving and the risks associated with it;**
- **the right of all persons to take an active part in decisions that affect them and, in particular, the right to refuse the administration of disproportionate treatments or to be kept alive by artificial means;**
- **the right of all persons to be assisted and accompanied in order to have their rights respected, especially when lodging a complaint or seeking recourse;**
- **the right of all persons to die with dignity.**

The respect of these principles is important for securing the rights of citizens as consumers. However, it is also vital to ensure that the rights are given concrete expression

within the health and social services establishments. The Minister therefore intends to:

- **have each establishment adopt a code of ethics that states the rights of users, the practices and behaviour expected of the staff, and the recourse available to citizens;**

- **require that the establishment provide each user with a copy of the current code of ethics upon admission;**

- **transform the current medical files into "user files" to show that they belong exclusively to the users, to keep track of all services received, whether medical or non-medical, and to allow users to make their files available to the health and social service professionals of their choice.**

To promote respect for users' rights, it is essential to encourage an open and responsible attitude and outlook among all staff members.

The Minister therefore plans to:

- **develop training programs and programs to sensitize staff members to the rights of users and the practices and behaviour that are conducive to ensuring respect for users' rights.**

1.2 Reinforcing assistance and companion service mechanisms

Ensuring recognition of users' rights could not be possible without mechanisms or means to help users exercise their rights. Users may feel the need to be better informed, to obtain assistance and to be accompanied when they want to lodge complaints. It is important that they be given ready access to resources geared first and foremost to promoting and representing their rights and interests at all levels of the network.

At the establishment level, the Minister intends to:

- **set up user committees in all public or private establishments that offer long-term physical or psychiatric treatment and residence or rehabilitation services;**

- **have user committees focus more on representing and protecting the rights and interests of users and assessing their satisfaction with the services received;**

- **make user committees responsible for establishing rules relating to their composition, while maintaining the requirement that the majority of members be users or, where applicable, close kin;**

- **provide user committees with the facilities they need to carry out their activities and a budget equal to 0.1% of the establishment's budget, with the minimum amount set at $5,000 and the maximum at $70,000;**

- **recognize the user committees' ability to manage the budgets earmarked for them, with the requirement that they provide their respective establishment's board of directors and the regional authority with an annual report on their**

activities, including a statement outlining the use of the sums thus received;

At the regional level, the Minister plans to:

- **establish an assistance and companion service for users in each region by appointing for such purpose a community organization already involved in this field.**

1.3 Making the complaint processing mechanisms clearer, more credible and more effective

Despite all the efforts made to prevent infringements of users' rights, some citizens may feel that their rights are not being respected. Users must be able to readily use recourse available to them. This presupposes first of all that they have access to a credible representative and that they are assured of an impartial analysis of their complaints and, if need be, the remedying of situations that violate their rights.

It is necessary to make a clear distinction between complaints addressed to the health and social services network and those addressed to professional associations.

1.3.1 Complaints addressed to the network

Responsibility for processing complaints of this type lies above all with the health and social services network. In view of this, it seems necessary that formal complaint mediation and processing mechanisms be established first and foremost in the locations where the services are provided, that is, in each establishment. It is also important to provide a procedure whereby users can appeal an establishment's decision to a higher authority. The Minister therefore intends to:

- **have each establishment's board of directors appoint a senior administrator to receive and process complaints;**

- **have each board of directors provide an annual report for the public, at the annual meeting, and a report for the regional authority outlining the number of complaints received, the subject of the complaints and the follow-up carried out;**

- **ensure that each regional authority receives and processes complaints from users unable to obtain a satisfactory response from the establishment and, for that purpose, provide the authority with the analysis and investigation powers it needs to fulfill its role;**

- **have each regional authority provide an annual report for the public, at the annual meeting, and for the Minister, outlining the complaints received, the establishments and organizations concerned, the subject of the complaints and the follow-up carried out.**

It is essential to have complaint processing mechanisms within the network that are known to users, credible and easy to use. Based on the reports submitted by the regional authorities, who will have received reports from the establishments, the Ministry will oversee and conduct an appropriate follow-up on the operation of these complaint mechanisms.

Finally, the Minister intends to:

- **reserve the authority to hear complaints already dealt with by the regional authority but with an outcome deemed unsatisfactory by the complainant;**

- **ultimately take any action considered necessary in the circumstances.**

1.3.2 Complaints addressed to professional associations

Responsibility for handling complaints lies above all with professional associations. However, the complaint processing mechanisms set up by them need to be better known to users, clearer and more credible. The Minister has therefore informed the Minister responsible for legislation respecting professional associations of the orientations chosen, namely to:

- **increase the number of persons representing the public on the Board of each professional association;**

- **ensure that the public is represented on the inspection committees of the various associations and the Office des professions;**

- **specify the professional associations' responsibilities with regard to informing the public and implementing adequate mechanisms for processing complaints;**

- **specify the responsibilities of the Office des professions with regard to assisting complainants and overseeing the way professional associations fulfill their responsibilities.**

2. CITIZENS WHO BENEFIT FROM SERVICES ADAPTED TO THEIR NEEDS

Since the early 1960s, the province of Québec has provided a range of health-care services free of charge to the population, without distinction of income, age, race or place of residence. As a result, financial barriers to accessibility have been greatly reduced and even eliminated.
Let us not forget that scarcely thirty years ago, illness could literally plunge people into financial ruin.

Today, citizens are faced with an obstacle of an altogether different kind. In order to make it possible for them to benefit from the services that best meet their needs, it will be necessary to:

- correct problems related to the accessibility of certain services to the entire population;

- adapt the services as a whole to the needs of particular groups.

The measures to support these policies will require substantial expenditures over the next few years, since they reveal needs which must be met. However, plans for developing services in response to those needs will be submitted annually to the government for approval; the government will authorize them on the basis of the economic situation, its budget policy and its ability to defray costs.

2.1 Correcting problems related to the accessibility of certain services to the entire population

The health and social services network has become very complex. It is made up of various establishments, professionals and community organizations, each serving its own types of clients, handling its own types of problems, offering its own types of services, and operating on its own work schedule. People have trouble finding their way around in this maze. They find it difficult to identify the resource that offers them the service they need, when they need it. For this reason, many people wind up going to the emergency room of a hospital. More than 48% of Quebecers use emergency services as their main contact with the health care system, compared with 30% of Canadians in general and 24% of Ontarians. About 5% of Quebecers use local community services centres (CLSCs) for this purpose.

People must often wait for long periods before receiving the services they require because the establishment is overburdened and the staff overworked. The situation in hospital emergency rooms is often cited in this respect. These waiting periods may be due to a chronic lack of resources. They may also result from a deficiency in the internal organization of the establishment's services or from a lack of cooperation among establishments within the network.

Sometimes the services offered may involve equipment or facilities that fall short of safety standards or are no longer appropriate to the clientele using them.

Finally, more and more people are using services peripheral to the health and social services network without receiving any information about their quality and effectiveness or the competence of the persons dispensing them. The so-called alternative therapies in particular come to mind here.

In order to correct problems related to the accessibility of certain services to the population in general, it will be necessary to:

- consolidate the front-line network;
- improve hospital emergency services;
- modernize and adapt facilities and equipment;
- define the role of alternative therapies and their place in the network.

2.1.1 Consolidating the front-line network

The Castonguay-Nepveu Commission had recommended that CLSCs be designated as the sole point of entry to the health and social services network. It was thought that this would make services more accessible and at the same time ensure continuity and a full range of services.

The recommendation was never adopted, for several reasons. The CLSCs never had the resources to properly perform the function expected of them. Private and community services gradually expanded to carry out a part of this role. The general hospitals in particular come to mind here. Some establishments in the network that were initially intended to be specialized resources gradually broadened their functions to become new points of entry to the network.

It is perhaps no longer possible or even desirable to assign the role of point of entry to the CLSCs alone. Private practices and hospitals, with their emergency services, will continue to be points of entry to the service network. However, it will be necessary to:

- be able to refer people easily within the health and social services network;

- consolidate the CLSC as a front-line public institution;
- ensure that standard medical services are offered either by CLSC doctors or doctors in private practice;
- encourage people to use the front-line network.

In order to facilitate referral within the health and social services network, the Minister intends to:

- **set up an information line accessible 24 hours a day, seven days a week in each region of Québec.**

This service will provide advice on first-aid treatment and information on available resources. It will also direct people to an appropriate establishment, organization or professional, if necessary. The regional information service will use the front-line services network of the territory.

In order to consolidate the position of the CLSC as a front-line public institution, the Minister intends to:

- **extend CLSC opening hours and expand their diagnostic services, taking into account the opening hours and the existence of other front-line resources, including private practices, in the territory;**
- **develop standard medical services in CLSCs rather than in hospital outpatient clinics;**
- **redirect the front-line social services in social services centres to CLSCs;**
- **target budget equity among CLSCs by raising the budgets of those that are relatively underfinanced, taking into account the populations they serve and the social and health services they provide.**

In order to better coordinate the activities of CLSCs and doctors in private practice, the Minister intends to:

- **have each regional board accredit, in accordance with its medical manpower planning, doctors in private practice who make a commitment to:**
  - **practise in a public institution as well;**
  - **orient their private practice to the needs of the population in their territory;**
  - **participate in specific programs such as prevention and home care services;**
  - **cooperate with other establishments in the territory to ensure that medical services are available 24 hours a day, seven days a week.**
- **reduce the fees of non-accredited doctors;**
- **enlist the Fédération des médecins omnipraticiens du Québec to work out the terms and conditions for applying these measures.**

To encourage people who need consultations to contact CLSCs and private practices first, the Minister intends to:

- **introduce a referral fee of $5.00 for any visit to a hospital that does not constitute:**

  - **an emergency;**
  - **a consultation following a hospitalization;**
  - **a consultation following a referral by a CLSC or a private doctor.**

2.1.2 Improving hospital emergency services

Citizens have been experiencing problems in the emergency rooms of hospitals since at least the mid-1970s. These problems reached a critical level in 1985. The consequences are widely known: people are forced to wait for hours in emergency; they are sometimes left on stretchers in corridors for excessively long periods because the centre is swamped; on other occasions, they must endure the problem of ambulances being rerouted.

From 1985 to the present, more than half a billion dollars has been invested in emergency services. The situation has greatly improved. The Tactical Intervention Group consolidated the improvements in March 1990. This group advises hospitals, regional boards and the Ministry in problem areas.

Further investments are necessary to adapt some facilities and equipment. But overcrowding in emergency services is not primarily due to a lack of resources. It can be explained essentially by various operational problems: the internal operation of emergency services and other hospital departments; the unavailability of specialists for consultations requested by doctors in emergency; the management of the use of hospital beds; the absence of regional management of the use of beds; relations between emergency and outside services, including the other establishments in the services network.

The problems of emergency services, moreover, reveal certain deficiencies of the services network, where the effects of the aging of the population on the demand for services have been felt the most, raising questions about the organization of our services for older people.

In order to continue to improve emergency services, the Minister considers it necessary to:

- **maintain the Tactical Intervention Group;**

- **implement an overall plan of action providing for:**

  - **the acceleration of the renovation programs for certain emergency rooms;**

  - **the fixing of a minimum and a maximum number of stretchers a hospital must have available, based on the total number of beds registered on its permit;**

  - **the registration of the number of stretchers thus determined on the hospital permit;**

  - **the establishment of a regional system to provide information on unoccupied beds and refer emergency cases to those beds;**

- **reexamine the organization of pre-hospital services, including ambulance transportation;**

- **eliminate 1,500 of the beds occupied by chronic patients in short-term care hospitals in order to:**

  - **phase out 3% of the short-term care beds used for chronic patients that are in excess of the extended care beds authorized in the permit;**

  - **eliminate 10% to 15% of the extended care beds authorized in hospital permits, particularly in regions with shortages of short-term care beds;**

- **reinforce the role of emergency services coordinators by giving them the status of head of the clinical department as well as additional powers to ensure that admissions to emergency services have priority over elective cases and to coordinate patients' leaves from the hospital, if applicable.**

2.1.3 Modernizing and adapting facilities and equipment

Citizens are faced with three particular problems when they use network facilities and equipment. First, outdated or poorly functioning facilities compromise the safety and quality of the premises. Second, much of the equipment is obsolete; this, coupled with the late acquisition of new technologies, means that clients do not have access to advanced-technology services and must put up with old, unsafe equipment. Third, patients must endure long waiting periods before they are admitted to short-term care beds, mainly because the beds are located in different areas from where they live.

The equivalent of 1% to 1.5% of the net value of the real estate of the network, estimated at some $8 billion, is spent every year to renovate facilities, on the assumption that the facilities will last from 75 to 100 years. Clearly, this assumption is false. Facilities, especially short-term care hospitals, are deteriorating at a much faster rate than this, especially since no budget existed for the renovation of facilities until recently. To make matters worse, changes in the clientele served accentuate the dysfunctional nature of the facilities. This is particularly true of reception centres and psychiatric institutions.

Québec now has enough short-term care beds, assuming that those beds are actually occupied by people requiring such care, in which case Québec would have a surplus of 2,234 beds in 1991. However, given the impact of the aging of the population on the use of short-term beds, this surplus quickly becomes a deficit of 27 beds in 1996 and 2,477 beds in 2001. Persons aged 65 and over require three times as many days of hospitalization in short-term care beds as people under 65 years of age.

Nevertheless, those estimates should not be applied automatically. Their accuracy must first be established, notably through validation of the standards on which they are based. Furthermore, the availability and efficiency of home care services could appreciably attenuate the needs anticipated. Some caution is in order, prompting us for the moment to set objectives equivalent to 80% of the projected needs.

Québec has made considerable expenditures over the past few years to ensure the accessibility of advanced technology. In 1986, it spent $10 million and now spends $15 million annually, an amount comparable to that spent by most European countries. But no amount was allocated

specifically for this purpose in the early 1980s. Thus, there have been serious delays, which now must be made up for.

In order to modernize and adapt buildings, the Minister considers it necessary to:

- **set up a large-scale program to preserve and functionally renovate buildings, especially residences for the elderly. This investment will be $400 million, or $80 million a year for five years;**

- **entrust establishments that have been functionally renovated with the responsibility of maintaining their assets with their own budget.**

In order to ensure access to advanced technology, the Minister considers it necessary to:

- **increase from $45 to $75 million the three-year budget for the acquisition of new technologies.**

In order to make up for the shortage of short-term care beds, the Minister considers it necessary to:

- **add 2,000 short-term care beds over the next 10 years in the regions where there will be shortages of them.**

2.1.4 Defining the role of alternative therapies and their place within the services network

Since 1980, people have been using so-called alternative therapies more and more frequently. Although data on this are incomplete, about one third of the population consults the some 7,000 practitioners of natural medicine. Of these, 85% are not recognized, practising outside of the health and social services network.

The support that some of these therapies receive from the Québec population bolsters the arguments of associations of practitioners who wish to be recognized and see their profession legalized. However, such recognition requires implementing mechanisms for certification and control.

In order to help such therapies find a possible place within the system based on their particular contribution, and in order to protect the public, the Minister, along with his colleague responsible for the application of malpractice laws, intends to:

- **hold, through a parliamentary commission, a public debate on:**

  - **criteria for recognizing alternative therapies;**
  - **criteria and mechanisms for evaluating the competence of professionals practising those therapies and accrediting them;**
  - **mechanisms for collaboration with the public sector without financing by the government of services offered by practitioners of alternative therapies.**

2.2 Adapting services to the needs of particular groups

The image of Québec's health and social services has changed significantly over the past few decades. The health and social services network has not always been able to adapt its services and approach in response to problems or new clientele. The reform must make services correspond more to the needs of the following groups of users:

- the elderly;
- young people in difficulty;
- the disabled;
- alcoholics and drug addicts;
- aboriginal nations;
- the anglophone community;
- the cultural communities.

2.2.1 The elderly

The number of people 65 years of age and over will increase by 40% in the next decade. By the year 2001, they will account for almost 14% of the population.

This demographic phenomenon is not the concern of the health and social services sector alone. It is known that 83% of the elderly people living in their natural setting are not limited in their day-to-day lives or the role they play in society. In fact, most want to remain active, but many do not manage to do so, because of prejudices and constraints that hamper them. That is why the Ministry, now responsible for the status of the elderly, put together a group of experts chaired by Mr. Jean Pelletier to propose measures to promote the autonomy of elderly and their participation in the life of the community.

The aging of the population will have a considerable impact on the demand for health and social services. The average cost per capita of providing health services to senior citizens is 6.3% higher than for people under 65. This disproportion is much more pronounced in Québec than in the U.S. (3.9%) or even in Ontario (4.7%), notably because of the greater use of institutional resources in Québec.

The higher incidence of health problems and disabilities among elderly people cannot alone account for the higher use of services. There are other factors, as well, such as the model of intervention used and the types of services provided. These factors may have a greater effect on the rate of increase of expenditures than will the aging population. In order to make services better suited to the needs of seniors, a number of measures must be undertaken simultaneously. The first measure concerns the efforts directed at helping them remain at home.

In 1988-1990, Québec spent $123 million on home care services, including $98 million on regular services and $25 million on intensive care services. Home care for elderly persons alone took up the lion's share of this figure, at $88.6 million. These resources enable CLSCs to reach out to 17% of the senior citizens in Québec and provide an average of 1.6 hours of service per person per week. This is very little compared with what appears to be needed.

The estimates which have been made to determine how much the budget for home care services should be increased speak for themselves. Thus, a total of $250 million would be required to ensure that all seniors whose situation does not justify institutionalization or extended care according to the standards currently used will receive the assistance they need to remain at home. By another estimate, $735 million would be needed to provide home care services to seniors which are proportional to their degree of disability. Even if the number of hours per week devoted to people with moderate or severe disabilities were lowered considerably, $575 million would still have to be allocated to home care services. Finally, more than $893 million would be required in 1991 to put Québec on a par with the country recognized as best fulfilling the home care needs of the elderly: Sweden, which provides 20% of its seniors with home care equivalent to 5.5 hours a week.

Despite the relatively modest level of development of home care services, results so far have been very encouraging, especially in intensive home care services, which have now become a more feasible, acceptable option to persons with considerable functional disabilities and their relatives. In addition, they help prevent or delay institutionalization, as well as avoid hospitalization and reduce the duration of hospital stays.

The second type of measure concerns assistance to relatives of seniors. It is erroneous to claim that families are not committed to caring for their elderly relatives, although social and demographic trends point to a diminished capacity to provide support. Between 70% and 80% of the basic care already provided comes from the elderly people's families. This care is a heavy physical, emotional and financial burden for them. Insufficient or belated assistance to relatives is a factor in the breakdown of support networks. There may very well be a link between exhausted relatives and cases of abuse and institutionalization.

The third type of measures concerns the quality of services in establishments. The problems of people using the residential and extended care network are becoming more severe. Factors coming into play including increasing age of users, loss of physical and cognitive abilities and the presence of more than one disease. As a consequence, between 1985 and 1987, the amount of time spent in assisting and nursing the elderly has jumped from 1.87 to 2.03 hours per week, an increase of almost 6%. This represents an extra burden of 2% each year.

Over the last three years, major efforts have been made to help establishments deal with this extra burden. These efforts, which were to wind up in 1990-1991, must be continued.

The fourth type of measures concerns the major increase in the number of spaces in extended care hospitals and residences.

It is estimated that about 7% of senior citizens live in extended care facilities. This places Québec ahead of France (5%), Great Britain (5%), the U.S. (5.3%) and Australia (5.9%).

For the last 10 years the Ministry has had a policy of encouraging the elderly to remain in their natural setting. However, the residential care ratio has been diminishing very slowly, dropping from 2.4% to 2% for the 65-to-74 age group and from 14.7% to 14.4% for people aged 75 and over. These percentages are considerably higher than those on which the estimate of the need for extended care beds and residential spaces is generally based. The standard used by the Ministry is based on a residential care ratio of 1.3% for the 65-to-74 age group and 10% for people aged 75 and over. Based on a strict application of that standard, a shortage of approximately 9,000 beds may be expected by the year 2,001 and 27,000 beds by 2011.

However, the real situation may prove all these projections wrong. First, the calculations are based on the assumption that assistance to seniors provided by their families will remain at a constant level over the years. Second, the calculations are based on a residential care ratio about 33% lower than the 1987 figure; if the real ratio were applied, the projected shortages would be 30,000 beds in 2011 and 55,000 beds in 2011.

Even assuming that families provide more support and that home care services have

more impact than anticipated, a minimum of 80% of the projected shortage will have to be made up for in the years to come.

The fifth type of measures concerns people who are losing their ability to function and who reside in homes with inadequate facilities that do not provide the support and assistance seniors require.

In order to help seniors remain in their natural setting, the Minister intends to:

- **encourage CLSC doctors and doctors in private practice to make house calls to persons who have difficulty getting around;**

- **give CLSCs the mandate to:**

  - **meet with elderly people to assess their needs in the area of home care services and to determine the types, frequency and degree of care they require;**

  - **offer their own medical or nursing services and personal hygiene services;**

  - **see to it that elderly persons obtain the material and housekeeping assistance they require, primarily by referring them to community organizations offering such services;**

  - **make it possible for elderly people to receive a direct allowance so that they themselves can hire the home care services they require.**

In addition, the Minister considers it necessary to:

- **raise the home care budget by $200 million, at $40 million a year for five years, and allocate it to:**

  - **home care services;**

  - **support, relief and emergency services for families;**

  - **the completion of the network of day centres so that their services are available in each of the regional county municipalities (RCMs) in Québec.**

- **ask CLSCs to provide home care services in:**

  - **private residences for seniors;**
  - **low-rent dwellings.**

- **develop an evaluation grid for the purpose of assessing the abilities and disabilities of elderly persons and their home care needs.**

In order to enhance the quality of life for senior citizens living in institutions, the Minister considers it necessary to:

- **annually increase the level of services offered in the institutions by allocating expenditures to respond to the extra burden of the clientele equivalent to 0.75% of the budget for that sector of activity.**

In order to meet the growing demand for spaces in institutions, the Minister considers it necessary to:

- **add 7,000 spaces in residential and extended care facilities by the year 2000;**

- **partially satisfy the need for additional spaces by buying spaces or services in private residences and self-financed reception centres so that they can offer appropriate services to people who would otherwise have to be admitted to public institutions;**

- **see to it that surplus beds and related material resources are redistributed within the same territory or a bordering territory.**

In order to eliminate the presence of so-called illicit homes, the Minister intends to ask CLSCs to:

- **enumerate the residences for the elderly in their territory;**

- **make arrangements with municipal authorities to obtain information on all room permits issued to authorize the housing of elderly persons;**

- **regularly visit residences housing elderly persons to assess their degree of autonomy;**

- **consider persons living in such residences as being eligible for home care services programs;**

- **report to the Ministry any residence for elderly persons in which the conditions or lack of care observed there can cause serious harm to its residents, so that legal action can be brought against that residence.**

2.2.2 Youth at risk

The transformation of values and lifestyles within Québec society has eroded the stability of the home environment and even the structure of the family itself. Separations and divorces are numerous; in 1986, three out of five marriages broke up. Already, one out of five households is headed by a single parent. When poverty accompanies conditions like these, the difficulties of young people and their families are amplified.

The problems young people are faced with cry out for attention. For this reason, the Ministry has given a committee of experts the mandate to make specific recommendations concerning young people in the formulation of the Health and Welfare Policy.

Each year, 50,000 youths are reported to the Director of Youth Protection. Almost half of the reports are retained. Of these, 12,350 were victims of physical abuse, sexual abuse, or various forms of negligence in 1989 alone. The cruelty these young people are subjected to leaves permanent emotional scars, which show up in developmental delays, personality disorders, sleep disorders and thoughts of suicide.

In many cases, the home environment is so harmful to children's or adolescents' equilibrium and development that they must be withdrawn from it. Many overburdened families rarely - and in some cases never - have access to resources that might provide them with support and assistance in fulfilling their parental roles. The situation deteriorates to such an extent that the placement of children in foster homes and other youth protection facilities is often perceived as the only way to ensure their protection. In 1989, 55% of the 16,532 children taken in charge by the Director of Youth Protection were living in foster homes or other facilities.

Other problems are then likely to appear. Children are shuffled from one facility to

another, decreasing their chances of ever finding a stable home environment. However, the *Youth Protection Act* helps some young people find a stable home environment through regular adoption. Only 665 children benefited from this provision in 1989-1990 - a small number in view of the some 3,800 Québec couples waiting to adopt children. Children's adjustment problems worsen as they get older. They first manifest themselves in developmental disorders (0-6 years), then in problems with their relationships, learning difficulties and personality disorders. In 1988, almost 17,000 of the students in Québec schools had behavioral disorders. In the same year, 35,000 secondary school students dropped out. Almost a third of the students did not obtain their secondary school diplomas.

Social maladjustment is also at the root of delinquency and vagrancy. In 1988, more than 6,000 adolescents were placed under court order under the *Young Offenders Act*. In the same year, youth protection directors rendered 4,500 decisions ordering reparations for misdemeanors. In fact, serious behavioural disorders were present in about 24% of the situations that led the youth protection department to take charge of young people. In 1989-1990, more than 25,000 12-to-17-year-olds were arrested for committing one or more offences. Since 1986, there has been a dramatic upsurge of 85% in violent crimes.

The consumption of illicit drugs by young people is also on the rise, appearing in children as young as 12, as indicated in the Bertrand Report. Youths are also contracting sexually transmitted diseases at a high rate; for example, 25% of all chlamydia cases appear in adolescents from 15 to 19 years of age.

Suicide is a particularly serious problem with young people. The suicide rate hovers around 24 per 100,000 for adolescent boys from 15 to 19 and 4 per 100,000 for girls in this age group. This rate is among the highest in the world.

Moreover, despite efforts made in the last few years, youth protection directors are faced with difficulties of their own: the number of cases referred to them exceeds their capacity to take them in; people who work with these youths are only too aware of the limits of the therapeutic approach and the high rate of recidivism. The process of finding solutions must be oriented mainly toward early prevention and setting up services geared to the young people's everyday environment. Families must have access to a variety of forms of assistance within their communities so that their children do not have to be placed in institutions or shuffled from one foster home to another. Finally, more flexible placement services must be made available to young people, and the quality of youth protection services must be improved.

In order to reduce the incidence and gravity of the problems of young people, the Minister intends to:

- **step up prevention programs aimed at young people in the areas of drug and alcohol abuse, sexually transmitted diseases (STDs), mental health (particularly suicide), dropping out of school, vagrancy, juvenile prostitution and violence.**

In order to ensure that children and families have access to the services they require within the community, the Minister intends to:

• in CLSCs,

- **develop or consolidate services for children under 12 and their families in order to detect cases of retarded development, prevent abuse, and intervene for the general purpose of supporting families and improving their capacity to provide good parenting;**

- **expand social services in schools, primarily at the elementary level, by decreasing the ratio of social services staff from 4,310 to 1 to 2,800 to 1;**

- **develop consulting services aimed specifically at 12-to-18-year-olds who are experiencing problems that are frequent in that age group (STDs, drug abuse) or serious problems (vagrancy, prostitution or juvenile delinquency);**

• in community organizations,

- **give high priority to supporting innovative projects within community organizations that are designed to assist children and their families, as well as young people who are experiencing difficulties integrating into society;**

• in each region,

- **set up family counselling services in each region to lessen the blow of separation and divorce for both adults and children.**

In order to prevent children from being placed in institutions or moved from one foster home or youth protection facility to another, the Minister intends to:

- **help fund projects aimed at creating local teams skilled in assisting troubled families, either through specific relief and support services for the parents most in need or, more generally, through services designed to improve parenting abilities;**

- **revise current practices regarding adoption.**

In order to make more flexible placement services available to young people, the Minister intends to:

- **encourage the establishment of an alternative temporary housing program for young people, oriented toward their social integration primarily through re-entry into the school system or entry on the job market;**

- **revise current practices regarding decisions about the placement of children or adolescents at risk with a view to:**

  - **avoiding placing them whenever possible;**

  - **offering them various possibilities for rehabilitation.**

In order to improve youth protection services, the Minister intends to:

- **continue to reduce waiting lists for youth protection services by implementing the *recommendations of the Harvey report*;**

- **ensure follow-up of families and young people whose reports were not retained under the application of the *Youth Protection Act* but who**

deserve special protection all the same;

- **follow up on the proposals made by the task force that looked into how the process of taking charge of young people could be improved.**

2.2.3 The disabled

For many citizens, the quality of life is lowered because a physical or mental disability causes them to lose some or all of their autonomy. The three most common types of physical disabilities are motor, hearing and visual disabilities.

The signs of mental disability are cognitive functions that are significantly below average, accompanied by the appearance of adjustment difficulties in childhood. The number of mentally disabled people in Québec is estimated at 200,000, or 3% of the overall population; special services are required by 1%. They should be given the chance to have a quality of life that is satisfying and as similar as possible to that of other citizens.

Since the late 1970s, Québec has devoted much attention to this area and now leads the industrialized world in providing services to the disabled. The creation of the Office des personnes handicapées du Québec, the adoption of the plan of action *On Equal Terms*, as well as actions in the fields of employment, education and support in everyday life have all greatly improved the lot of the disabled. But some of the stated objectives related to integration have not been reached. Furthermore, adaptation and rehabilitation services are still not easily accessible in remote regions. Families of the disabled must be able to count on better outpatient services and benefit from relief and emergency measures. As for the disabled individuals themselves, action must be aimed at facilitating their social integration and entry into the work force, as well as at helping them maintain and develop their functional abilities. In addition, the services must be offered as close as possible to their day-to-day environment.

In order to facilitate their social integration and entry into the work force, the Minister intends to:

- **reintroduce the government hiring program aimed at placing disabled persons in the public service to eventually constitute 2% of its labour force;**

- **bolster hiring programs aimed at placing disabled persons in the private sector;**

- **increase the number of positions in apprenticeship programs.**

In order to help them maintain and develop their functional abilities, the Minister intends to:

- **consolidate, within rehabilitation centres, outpatient services for early childhood development and for the development of young people with mental disabilities;**

- **allocate 650 spaces for long-term intensive functional rehabilitation.**

In order to offer them services as close to their homes as possible, the Minister intends to:

- **set up, within health and social services establishments, multidisciplinary adaptation-rehabilitation teams for persons with**

hearing, visual and motor disabilities in regions where those basic services are not currently provided;

- **increase the budget for home care services for disabled persons and the budget for relief and emergency services for their families;**

- **make available a larger number of dwellings adapted for disabled adults, in collaboration with the Minister responsible for the Société d'habitation du Québec.**

2.2.4 Alcoholics and drug addicts

It is difficult if not impossible to determine the exact number of people who have a problem of drug or alcohol abuse. It is possible, however, to assess the economic, social and human consequences of this problem: physical and psychological dependency, reduced quality of life, poverty, crime, homelessness, unemployment, illness, conjugal violence, and traffic accidents, among others.

In Québec, it is estimated that the consequences of the use of illicit drugs other than alcohol cost the province $1.2 billion a year, which breaks down to $818 million in health service costs, $197 million in lost productivity, and $173 million in costs to the judicial system.

The consequences of alcohol abuse cost the Canadian economy $5.2 billion a year; Québec's share of this figure approaches $1 billion.

The consumption of alcohol has risen almost unabated for the past 40 years in Québec, dipping only slightly toward the end of the 1970s. At present, more than 6% of the Québec population has a problem of alcohol dependency. But a new phenomenon is emerging: a growing number of women and adolescents are affected. Health and social services must take this new reality into account.

Drug use, is a more recent phenomenon. The appearance of hard drugs and their easy accessibility are problems that need to be addressed. Prevention must be stressed, a wider range of services must be offered in regions where they are lacking, and research oriented toward social intervention must be developed.

In order to step up prevention efforts, the Minister intends to:

- **give regional authorities the mandate to coordinate prevention programs carried out by organizations involved in all the different areas;**

- **increase budgets for programs aimed at the prevention of drug addiction in community organizations and establishments;**

In order to offer a wider range of services in regions where they are lacking, the Minister intends to:

- **add 30 new outpatient rehabilitation units;**

- **create 180 alternative residential and rehabilitation spaces and adapt activity programs to the particular needs of women and adolescents;**

- **add 50 spaces for medical detoxification in hospitals and 50 spaces for detoxification in non-medical units;**

- **subject public and private establishments offering rehabilitation services to minimum standards of quality and implement a mechanism for recognizing private resources.**

In order to develop research oriented toward practical intervention, the Minister intends to:

- **create, in collaboration with the Conseil québécois de la recherche sociale, using one or more establishments within the health and social services network, a drug addiction research centre, which is to be affiliated with a university and to have the mandate of researching, teaching and dispensing specialized care.**

2.2.5 Aboriginal nations

Aboriginal people, who number 50,000 in Québec, form ten nations divided into three linguistic groups: Iroquois, Algonquin and Inuit.

Aboriginal people are tending to use the government services set up for the general population more and more frequently, particularly social, health and educational services. Such services must therefore be adapted to these diverse cultures. It is important to reaffirm the right of aboriginal nations, long recognized in Québec, to have access to health and social services appropriate to their particular needs and way of life. The Government is in favour of indigenous communities managing their own services for themselves. With this in mind, the Minister intends to:

- **hand over to the Inuit and Cree nations the mandate to manage health and social services in the Kativik and James Bay territories, respectively;**

- **negotiate agreements with the Abenaki, Algonquin, Attikamek, Huron, Micmac and Montagnais nations giving them control and management of the services in their own territories;**

- **make it easier for aboriginal personnel to be trained by seeking the cooperation of the Ministère de l'Éducation and the Ministère de l'Enseignement supérieur et de la Science in order to adjust requirements for admission to educational institutions to the particular situations of aboriginal people;**

- **meet the specific training needs of non-aboriginal personnel working in the aboriginal community.**

2.2.6 The anglophone community

All institutions within the health and social services network must remain sensitive to the particular needs of the anglophone community, which has contributed to the development of Québec society for more than 200 years. Moreover, it is recognized that English-speaking people are legally entitled to receive services in their own language wherever a regional access program provides them.

In order to better adapt the services to the needs of the anglophone community, the Minister intends to:

- **implement programs of access to health and social services for anglophones as prepared by the**

regional authorities concerned and ensure that they are followed up;

- **take into account the linguistic affiliations of establishments working with this community in implementing the reform;**

- **favour the hiring of personnel from the anglophone community within the Ministry and the network.**

The Minister also intends to:

- **ensure that all establishments within the network hold the certificate of francization required by the Charte de la langue française.**

2.2.7 The cultural communities

The cultural communities, which account for more than 10% of the Québec population, have backgrounds other than Québec francophone, anglophone or aboriginal cultures. Their values and ways of life are highly diversified. These Quebecers must have access to services that take into account their particular situations. To this end, the Minister intends to:

- set up a special access program for cultural communities;

- set up an employment equity program for these communities within the health and social services network;

- take into account the cultural affiliations of establishments working with these communities in implementing the reform; and

- form a bank of interpreters on Montréal Island to support the personnel of the establishments concerned;

- reserve a wing or a unit for members of the various cultural communities in certain residential or extended care facilities, where demand warrants it.

3. CITIZENS WHO RECEIVE SERVICES AS CLOSE TO THEIR COMMUNITIES AS POSSIBLE

As far as citizens are concerned, having access to services means receiving them as close to their communities as possible. It must be recognized that enormous efforts have been made in recent decades to bring services closer to communities. The completion of the CLSC network, establishment of homecare reception centres in almost all CLSC territories, and a more equitable apportioning of general practitioners throughout Québec are eloquent examples of these efforts.

However, it must be noted that there are still shortcomings. The public does not understand or accept not having easy access to basic services because of an absence or shortage of professionals in their territory. Their frustration is still more understandable when it comes to medical services, because of the vital nature of these services and especially the importance of physicians in any health system. Because of the lack of professional resources, people must travel to larger centres to obtain basic services or simply do without them. Yet they pay the same taxes as other Quebecers.

The lack of professional resources in communities can be attributed either to a genuine shortage of certain types of professionals throughout Québec or to their poor geographical distribution.

People are particularly concerned about four categories of professionals: physicians,

nurses, rehabilitation personnel and professionals in the social sector.

3.1 Physicians

Québec has no shortage of physicians; rather, it ranks among the leading industrialized countries in this regard and, together with British Columbia, is the Canadian province with the most physicians per capita. Québec has 4% more physicians than Ontario and 7% more than Canada as a whole. Indeed, in recent years, the number of physicians has grown three times as much as the population. In addition, Québec has the most specialists per capita: 8% more than Ontario and 14% more than Canada as a whole.

Yet some medical services are not always easily accessible in the regions. In family medicine, the situation has considerably improved in recent years, and the volume of services provided is about equal from one region to another. However, this is not the case for specialties, particularly basic specialties such as general surgery, internal medicine, psychiatry, obstetrics, anesthesia and radiology.

Two factors are involved: a shortage of certain specialties and poor geographical apportioning of specialists.

The shortage is related to the fact that fewer and fewer students are going into the basic specialties such as internal medicine and general surgery; instead, they are opting for ultraspecialties, which are considered more attractive both because they pay more and because they emphasize technical rather than clinical aspects of practice. Ultraspecialties, however, are concentrated in larger centres. There are three to five times as many specialists in the university regions (Montréal, Québec City and the Eastern Townships) than in the other regions, and seven to fifteen times more anesthetists, psychiatrists and internists. Almost three-quarters of new graduates in the specialties begin to practise in university regions. As a result, the use of specialized services is one and a half times higher in Montréal than in non-university regions. In psychiatry, the gap is even wider.

The other consequence of this imbalance is that people from the intermediate and outlying regions must travel to the larger centres to obtain certain medical services. For example, people from the North Shore consume half of their specialized services outside their region. In Abitibi-Témiscamingue and the Lower St. Lawrence-Gaspé region, this proportion is more than one-third. The travel required involves extra costs to the people from these regions. In sum, it is the very principle of universal access that is compromised.

To enable the people of all regions to receive services as close to their home communities as possible, it is necessary to:

- make up the present shortage in certain basic specialties;

- foster better distribution of physicians among the regions;

3.1.1 Making up the shortage in basic specialties

To make up the shortage in basic specialties, the Minister is asking the government to:

- **increase the number of admissions in internal medicine and general surgery;**

- **ensure that this increase in admissions translates into a higher**

number of physicians practising in basic specialties rather than ultraspecialties;

- **place greater value on basic specialties when negotiating remuneration conditions for specialists.**

3.1.2 Improving the geographical distribution of physicians

To improve the geographical distribution of physicians, it is necessary to:

- create more links with faculties of medicine;
- reinforce the application of medical staffing plans;
- regionalize the budget for the medical services program administered by the Régie de l'assurance-maladie du Québec.

Creating more links with faculties of medicine

Because of the strategic position of medical faculties in student recruiting and career guidance, greater use must be made of the services of these faculties to make up shortages of physicians throughout Québec.

Therefore, the Minister intends to:

- **twin each region of Québec with a faculty of medicine;**

- **assign each faculty responsibilities related to medical personnel in the regions with which it is twinned, i.e., it must:**

  - **foster the recruitment of students from these regions;**

  - **foster teaching in the establishments of these regions, especially for family medicine and basic specialty programs;**

  - **direct their resident physicians towards the regions with a shortage of resources;**

  - **provide stimulating professional supervision and opportunities for revitalization to physicians already practising in these regions.**

Reinforcing the application of medical staffing plans

The application of medical staffing plans for the 1987 to 1990 period did not bring significant change in the geographical distribution of physicians, for three reasons.

First, more than 55% of the specialists who began to practise in Québec during this period were appointed professors and were thus able to obtain 100% remuneration from the Régie de l'assurance-maladie du Québec despite their practising in a university region. If they had not been appointed professors, their remuneration rate would have been only 70%. There are currently almost 450 physicians in this situation in Québec.

Second, medical staffing plans apply only to physicians employed in establishments. They do not regulate those in private practices. Since new general practitioners in Québec have increasingly opted for only private practice, they are not subject to the medical staffing plans. The proportion of general practitioners practising only in doctor's offices has risen from just 20% in 1987, to 54% in 1988-1989, and to 65% in 1989-1990.

Third, some establishments recruited a larger number of physicians than authorized under their medical staffing plans.

To increase the impact of medical staffing plans, the Minister intends to:

- **limit for three years, to 150, the number of physicians who begin to practise in a university area and are exempt from reduced remuneration because of their appointment as a professor or researcher;**

- **include private medical practices in the regional medical staffing plans;**

To ensure compliance with medical staffing plans, the Minister intends to:

- **require that any appointment of a physician in an establishment be ratified both by the establishment and the regional authority, where:**
  - **appointments exceed the number authorized in the medical staffing plan;**
  - **the establishment has failed to provide a plan;**
  - **the establishment is temporarily without a medical staffing plan, e.g., during the period preceding the approval of a new plan;**
  - **the establishment is temporarily without a plan approved by the Minister.**

- **impose an embargo on any real-estate or technological development in establishments that make appointments beyond authorized medical staffing plans. The embargo will be maintained as long as these establishments fail to comply with the plan.**

Regionalizing the budget of the Régie de l'assurance-maladie du Québec (RAMQ)

The RAMQ budget is allocated by territory to the number of physicians rather than the population. The consequence of this method is that people are obliged to travel to where physicians practise. However, if the RAMQ budget were allocated in relation to the population of each region of Québec, there would be a strong incentive for physicians to practise in the regions. The RAMQ must therefore allocate its budget differently.

To regionalize the RAMQ budget, the Minister intends to:

- **ask the RAMQ to allocate its medical services budget by region, according to the demographic characteristics and health of the population;**

- **take appropriate action so that each such regional medical services budget will be closed and will remain under the management of the RAMQ;**

- **require that the cost of medical services used by residents of a given region be defrayed from the budget for that region, regardless of the region in which the services are actually received;**

- **establish a differentiated fee schedule based on the shortage or surplus of physicians and the remoteness of the region.**

- **review the fee differential among the regions every three years. Physicians will no longer be allowed to enjoy higher fee schedules for the rest of their lives after only three years of lower fees. This will make it possible**

for the differentiated fee policy to be self-financing;

- **have regional authorities manage a special annual budget for the remuneration of physicians on fixed salaries;**

- **ask the regional authority each year to propose measures to correct budgetary shortfalls, if any.**

Such corrective action could involve:

- the number of physicians;
- remuneration conditions;
- differentiated fee schedules;
- changes in the practice of medicine.

3.2 Nurses

The situation in the nursing profession is becoming increasingly critical in Québec. In 1980, Québec had the second-highest number of nurses per capita of any Canadian province, coming just after Ontario. By 1988 it had slipped to seventh place. Québec now has almost 10% fewer nurses per capita than Ontario or Canada as a whole. However, it still has about 8% more nursing assistants.

Although the number of working nurses increased by 20% from 1980 to 1988, the demand increased by almost 24%. At the present time, 9% of nursing positions are vacant—twice as many as in 1980. The percentage of vacant positions is even higher in the Ottawa Valley (14%) and in psychiatric hospitals (17%).

There are many reasons for this situation. For the past ten years, fewer nurses have been trained each year. In 1980 there were 2,800 nursing students. Now there are barely 2,000. Increasing numbers of nurses are leaving the profession. Québec also has a net loss with regard to interprovincial migration that seems to be increasing each year. Finally, the gradual specialization of nursing care tasks has led to a 7% drop in the demand for nursing assistants.

If the nursing profession is less attractive now, it is because working conditions have deteriorated over the years. Many jobs are now considered precarious (60% of nurses occupy temporary positions) and the schedules are difficult. Many nurses consider that they do not have enough autonomy in their work and that their professional expertise is not sufficiently recognized.

The last round of bargaining was a first step in improving the working conditions of nurses. For example, by the end of the collective agreement, the base salaries paid to nurses will constitute 85% of the total professional salaries in the network. Bonuses for responsibilities have been increased and, above all, a professional job level (Bachelor of Nursing) was introduced. In addition, measures are planned to improve the working conditions of part-time staff and gradually increase the number of full-time positions. Finally, to compensate for and alleviate the inconveniences related to holiday work, bonuses for night and weekend shifts have been substantially increased.

Therefore, the Minister intends to:

- **evaluate rigorously the impact of negotiated measures on the profession's ability to attract and keep nurses;**

With regard to the organization of nursing care in establishments, some nurses' associations advocate a degree of

specialization that leaves little room for nursing assistants and orderlies.

However, it is clear that if we were to make all nursing care the exclusive domain of nurses, particularly Bachelors of Nursing, the shortage would be even more acute. Nursing assistants must have a place in the network. So that the public can continue to have access to high-quality nursing care administered by competent personnel, the Minister intends to:

- **develop an overall nursing care policy in order to:**

  - **determine present and future nursing manpower requirements;**

  - **specify concrete measures to attract, retain and allocate this manpower;**

  - **grant priority to those organizational structures that foster job enrichment and make effective use of the various skills of nurses, nursing assistants and orderlies alike.**

3.3 Rehabilitation personnel

The expectations of many groups, including disabled and elderly persons, have led us in recent years to stress the maintenance of autonomy. This situation has created an increased demand for rehabilitation services. Although the number of rehabilitation professionals has increased considerably during the past decade, there is now a shortage of occupational therapists, speech and hearing therapists, and rehabilitation technicians. This shortage is more pronounced in some regions, since the personnel tends to be concentrated in large centres.

Recently, efforts have been made to meet the need. The Université de Montréal has increased its admissions in speech therapy by one third (from 25 to 35). The Université de Sherbrooke has begun offering a Master's-level program in mobility assistance. In addition, the government increased admissions in occupational therapy programs by almost 20%, from 25 in September 1989 to 30 in September 1990. The main purpose of this last measure was to correct the particularly critical situation in reception centres for the elderly.

Therefore, the Minister intends to:

- **evaluate the impact of an increase in admissions on the availability of manpower;**

- **develop a policy that will make it possible to train a sufficient number of rehabilitation personnel, foster maximum use of both professional and technical skills and ensure equitable distribution of such resources throughout Québec.**

3.4 Personnel in the social sector

To date, human resources in the social and psychosocial sectors, such as specialized educators and social workers, have not received any particular attention from the Ministère de la Santé et des Services sociaux. Yet they often work in difficult fields and with people whose needs are very complex, e.g., young people with adjustment problems, victims of child neglect, battered women or elderly victims of violence.

It is therefore necessary to initiate in this sector a re-evaluation comparable to the one that has long been conducted in the health sector. Therefore, the Minister intends to:

- **proceed to make an inventory of positions available for these types of professionals throughout the health and social services network;**

- **determine the level of difficulty of recruiting and keeping professionals in each region and category of establishment;**

- **ensure that the number of professionals trained is at least sufficient to fill these positions.**

4. CITIZENS WELCOMED, HELPED AND TREATED BY DEDICATED PERSONNEL

Citizens must be able to count on personnel who are not only friendly but also attentive to their needs, and able to provide effective and personalized service. On the whole, the comments received in this regard have been largely positive.

Nevertheless, users sometimes criticize the behaviour of personnel. Some complain that they are received and treated with indifference. Others sometimes refer to assembly-line services in which routine takes precedence over an individualized approach.

These are no doubt isolated cases; nevertheless, they harm the quality of relations between clients and personnel. In this regard, it is generally shown that the quality of these relations is closely linked to the personnel's level of satisfaction in carrying out their duties. In the health and social services sector, this level of satisfaction also affects the ability of the network to attract and keep the necessary personnel.

Some phenomena, such as the high departure rate, increased absenteeism and grievances, tend to indicate shortcomings in the quality of working life. To increase the quality of service, it is necessary first to improve the employees' quality of working life. This objective can be achieved only by correcting the many causes underlying the lack of motivation in some employees and by paying maximum attention to human resource management.

For citizens to be welcomed, helped and treated by dedicated personnel, it is necessary to:

- motivate the personnel;
- recognize the personnel's value;
- give the personnel opportunities to meet new challenges.

4.1 Motivating the personnel

The personnel must be able to influence the future of the establishment. They must also feel that their voice counts in determining how to improve the quality of services and that their opinions are sought and listened to when deciding on the organization of the work environment. Having a voice in decision-making, they can develop the greater sense of belonging that is so necessary to job motivation. Specific mechanisms must be introduced for this purpose.

In addition, Bill 160, although necessary to the maintenance of essential services, generated additional sources of frustration for the personnel.

4.1.1 Personnel participation in the general orientation of the establishment

The personnel must be involved in decisions regarding the direction that the establishment intends to take and, insofar as

possible, in improving the quality of services on an ongoing basis. Therefore, the Minister intends to:

- **allow various categories of employees and professionals to sit on the board of directors of the establishment in which they work;**

- **reserve a seat for physicians and another one for nurses among the seats set aside for employee and professional representatives on the board of directors of a hospital;**

- **ensure that the employees of establishments are informed and consulted on the priorities and orientations of the establishment;**

- **ask the establishments to hold, for the employees, at least one annual assembly open for discussion.**

4.1.2 Staff participation in the organization of their work environment

If employees are to feel comfortable with the rules of their workplace, they must at least be able to influence these rules so they will reflect the particular realities of the workplace. There are possibilities in this regard, but they have never really been tried before. Therefore, the Minister intends to:

- **give the regional and local levels authority to negotiate non-financial clauses related to human resource management, organization of work and professional development.**

The *Act respecting the process of negotiation of the collective agreements in the public and parapublic sectors* allows agreements to be reached at the local level in order to foster adjustment to the specific character of each workplace. These provisions may, for example, deal with working hours and the work week, merging of job positions, creation of float teams, transfers within an establishment, annual leave, professional practices and responsibilities, etc.

To implement these changes, the Minister intends to:

- **reach an agreement with the unions to place a moratorium on non-financial clauses that could be raised pursuant to a local or regional agreement.**

The Minister also intends to:

- **ask the establishments to entrust the managers responsible for providing services with the appropriate responsibilities in terms of human resource management, notably organization of work, professional development and personnel evaluation.**

4.2 Recognizing the personnel's value

Recognizing the personnel's value involves acknowledging professional competence, achievements and results obtained. It consists in fostering greater professional autonomy, reducing difficult working conditions and recognizing excellence in a tangible manner.

4.2.1 Fostering greater professional autonomy

The Professional Code has been used since 1973 as a legal framework for relations

between professionals and their clients and among categories of professionals. It regulates the activities of 40 duly recognized corporations, including 22 in the health and social services sector alone.

The Code was created for two purposes: to protect the public and to foster cooperation among the professions. It provided for two legal statuses for corporations: reserved title and exclusive practice.

To foster cooperation among the professions, the Code also provided for the delegation of services. Although the Office des professions is supposed to ensure that any corporation required to do so by law determines among the services reserved to its members those that may be performed by persons other than its members, the corporations have so far done little in this regard.

Some 15 years after the legislator's decision to make the delegation of services mandatory, only three of the seven corporations involved had adopted regulations to this effect, and many had used the delegation of services provision to enlarge their fields of practice. Consequently, this has had the effect of reinforcing the hierarchization of professions and creating new obstacles to the organization of work and interdisciplinary cooperation.

To promote greater flexibility in the organization of work and improve interprofessional relations in establishments, the Minister intends to ask the government to:

- **review the professional regulations over the next few years with a view to replacing exclusive fields by exclusive acts with restricted distribution or by reserved titles.**

4.2.2 Reducing difficult working conditions

Working conditions in the establishments are sometimes difficult, due to job insecurity, difficult schedules and heavy workloads. The last collective bargaining session made it possible to correct some of these problems. Therefore, the Minister intends to:

- **evaluate the impact of action taken to reduce the number of casual employees and increase the proportion of permanent positions from 40 to 60%;**

- **evaluate the impact of action taken to ensure better sharing of inconveniences and fairer compensation for more difficult working hours and schedules (night, weekend and holiday work).**

The Minister also intends to:

- **ensure that the objectives of Bill 160 have been met and determine both its positive and its negative effects on beneficiaries, establishments and workers.**

A mandate in this regard was given to Messrs. Norbert Rodrigue, Executive Director of the Conference of regional health and social services councils, and Maurice Lemelin, Director of Parapedagogical Services at the École des hautes études commerciales.

4.2.3 Recognizing excellence

Personnel achievements, innovative initiatives and commendable behaviour with respect to improving the quality of services deserve to be not only noted, but also

appreciated and recognized. The same is true for human resource management, the quality of which has considerable bearing on the quality of client-personnel relations. In this regard, user satisfaction is synonymous with personnel and management satisfaction.

Therefore, the Minister intends to:

- **create provincial merit awards recognizing the quality of the services provided by personnel and the quality of human resource management in the network;**

- **ask the establishments and regional authorities also to create such merit awards.**

4.3 Giving personnel opportunities to meet new challenges

The acquisition of new skills and work experiences results in benefits to both the employees and the organization. Therefore, the health and social services system must invest more in professional development and encourage mobility.

4.3.1 Ensuring that human resource development becomes an ongoing concern

It is important to encourage all establishments to grant absolute priority to the human resources on which the quality of their services is based. Therefore, the Minister intends to ask each establishment to:

- **create an annual action plan for staff development;**

- **prepare this plan in cooperation with the personnel and include in it measures related not only to professional development and mobility, but also to employee orientation, evaluation and career guidance.**

4.3.2 Increasing professional development activities

Until quite recently, the health and social services sector spent only about one-third as much for on-the-job training as the public service or the education system. During the last round of collective bargaining, improvements included training for nursing personnel and management. The Minister intends to:

- **continue catching up with regard to funding, so that in three years the amounts devoted to upgrading human resources in the establishments will be comparable with those invested by the education system and the public service;**

- **have the Ministry give annual courses in Québec City and the regions for board members, managers and employees of establishments, regional authorities and community organizations in order to develop team spirit in the service sector and permit discussion on:**

  - **priorities and objectives;**
  - **strategies and orientations to emphasize;**
  - **ways to cope with constraints;**
  - **contributions and roles expected from each other.**

4.3.3 Increasing mobility

Mobility fosters innovation and dynamism. It may mean a more diversified and enriching career path for employees. It is eminently desirable, especially for employees, managers and organizations. Several factors almost completely reduce mobility in the network — for both personnel and directors general. Therefore, the Minister intends to:

- **develop and implement a mobility policy for management and particularly directors general;**

- **reach an agreement with the unions regarding mechanisms to be implemented so as to increase the mobility of unionized personnel.**

II. THE CITIZEN AS DECISION-MAKER

Citizen participation in the management and orientation of the health and social services network became established with the reform of the 1970s as one of the values on which the network should be based. This value retains its full relevance today. The reason is very simple. The services are designed for the citizens; it is they who pay the costs; and it is they who are in the best position to state what they expect from the network.

In practice, citizens do not have the impression that they exert a real influence over the network, for three main reasons. The real decision-making power in the network is exercised by the Ministère de la Santé et des Services sociaux. In so doing, it dictates what should be done and, frequently, the way it should be done. The people who are members of the various decision-making structures of the network then perceive themselves more as executing decisions made elsewhere than as being in a position to have a real influence.

Citizens form a minority in the boards of directors of the network. Representatives of the health and social services establishments, professionals, personnel and managers play a determining role in decision-making, and ordinary citizens find it difficult to perform their duties as spokespersons for the community.

Lastly, they really have the impression that the network is accountable for its management and decisions more to its own members than to the people it serves. The establishments and professionals working in them do, of course, have to answer for the services they provide their citizens. But they rarely seek a contribution from citizens regarding the orientation of services and the evaluation required to improve them. Furthermore, there is no real channel for soliciting such contributions and enabling citizens to exert a real influence.

To restore the citizen to the centre of the system as a decision-maker, three orientations have been adopted:

- decision-making as close to the action as possible;
- citizens at the heart of the decision-making process;
- citizens accountable for their decisions.

1. DECISION-MAKING AS CLOSE TO THE ACTION AS POSSIBLE

Every day, the Ministère de la Santé et des Services sociaux makes decisions that should and could advantageously be made at other levels. Bringing decision-making as close to the action as possible requires, first and foremost, that the Ministry redefine its role. It should divest itself of certain functions it fulfills at the present time, and in particular transfer them to the regions.

This transfer is not oriented solely toward the regional level. Increasing the responsibilities assumed by the regional authority must not take the form of a new centralization of powers at this level; insofar as the action itself is local, decisions must be made locally. Otherwise the regional authority could rapidly tend to direct the establishments rather than supporting them as it should, to intervene directly in services instead of coordinating them on a regional level, to regulate and complicate just when the Ministry itself is deregulating and attempting to simplify structures. Bringing

decision-making as close as possible to the action also presupposes a clarification of the role of the regional authority.

The granting of increased powers to the local level makes it necessary for each of the health and social services establishments to have very clear roles, responsibilities, and mandates, and for the limits of its powers to be specified, if only to maintain consistency throughout Québec's health and social services system. Bringing decision-making as close to the action as possible also means a review of the role of the establishments of the network.

To ensure that decision-making is as close as possible to the action, it is necessary to:

- implement a real decentralization to the regions;
- define clear responsibilities and functions;
- grant the establishments real latitude.

1.1 Implementing real decentralization to the regions

It is unthinkable to continue dealing directly at the central level with all the requests coming from the 900 establishments, 1,300 subsidized community organizations and thousands of professionals in the network. The personnel of the Ministry, despite the best will in the world, cannot have the same knowledge of the needs, particular features, dynamics and resources of the community as the people of the community themselves.

Moreover, while the Ministry is dealing directly with each of the network's demands, it cannot assume the responsibilities that really come under its jurisdiction. In a word, it does not provide the leadership expected of it, which it alone can offer.

At the present time, the regional authorities have neither the power nor the means to adapt services to the needs of the people in their territory. Even though their mandate has been broadened since 1970, their powers remain restricted and definitely inadequate to carry out the arbitration required for a genuine planning and regional organization of services. In such a context, the establishments discuss their development projects, their financial problems or their equipment needs directly with the Ministry.

In order to implement real decentralization of the health and social services network, the Minister intends to:

- **create a regional level responsible for the development and organization of health and social services;**
- **abolish the present health and social services councils;**
- **create a health and social services board in each of Québec's administrative regions, except in Northern Québec, where there will be two, to take into account the particular characteristics of the Inuit and the Cree;**
- **grant hiring priority within these boards to the current personnel of the health and social services councils.**

In order to proceed with decentralization towards regional and local levels, there must be a clear distinction between the responsibilities of:

- the Ministry;
- regional boards;
- health and social services establishments.

1.1.1 The Ministry

The Ministry remains the final body responsible for the objectives set by the legislator. Responsible for the general mandate to regulate the system and to define and control its general operating rules, its responsibility can be summed up essentially as overall management and interregional coordination. The Minister responsible is accountable, in the name of the government, to the National Assembly and to the people.

To that end, the Minister intends to redefine the Ministry's mission around the following functions:

- **proposing to the government the orientations and objectives of the health and social services sector;**

- **preparing policies and programs, ensuring their implementation and assessing their effectiveness;**

- **distributing fairly among the regions the human, financial and material resources and ensuring that they are efficiently used;**

- **assuming the following responsibilities at the central level:**

  - **planning of tertiary services, including new health technologies;**
  - **accreditation of establishments, including private establishments under contract;**
  - **negotiation of agreements and collective agreements;**
  - **determination of the framework of resource management;**
  - **authorization of major capital expenditure projects;**
  - **coordination of research;**

- **adopting the necessary protection measures when public health is in jeopardy.**

1.1.2 Regional boards

The regional boards are really in charge of the development and organization of health and social services in their territory. In this capacity they share with the Ministry as associate agencies the management of the public services network.

The Minister intends to entrust the following functions to the regional boards:

- **ensuring citizen participation in the management of the public health and social services network and guaranteeing respect for the rights of citizens;**

- **defining their priorities in terms of the realities of their territories and the health and well-being objectives set by the Ministry;**

- **deciding on the organization of services in their territory and assessing their effectiveness, without ever acting as a direct service provider;**

- **allocating budgets to establishments and community organizations and ensuring they are used efficiently;**

- **accrediting physicians in private practice;**

- **coordinating the action of professionals in private practice, establishments, intermediary resources and community organizations, promoting cooperation with other development agents in the community and drawing up the necessary agreements with other regions;**

- **establishing measures designed to protect public health and ensuring the social protection of individuals, families and groups;**

- **encouraging establishments to join together for efficient management of their resources.**

1.1.3 Health and social services establishments

The health and social services establishments constitute the basis of the network and they all share the same responsibility with regard to the services to be provided for the people of Québec.

The Minister intends to entrust the establishments with the following functions:

- **offering the population high-quality, accessible, continuous services:**

  . **with a view to contributing to attaining objectives centred on reduction of problems of health and well-being and on the satisfaction of the needs of specific segments of the population;**

  . **in light of their mission, the resources available, and the regional organization of services;**

- **receiving citizens and assessing their needs;**

- **referring citizens, when applicable, to the appropriate resources;**

- **efficiently managing their human, material and financial resources, with the obligation to participate in joint purchasing and procurement;**

- **participating in the evaluation of the care and services administered and the regional service programs.**

1.2 Defining clear responsibilities and functions

The roles and functions of the establishments making up the health and social services network must be clearly defined. This definition is even more important in a context of decentralization in order to see exactly where the autonomy of each establishment is exercised, and where the necessary cooperation should begin.

The definition of the roles and functions of the establishments in the network must take into account the growing contribution of community organizations in the health and social services sector. It must also consider the impact of decentralization on the organization of public health.

Precise details must be established with regard to:

- health and social services establishments;
- community organizations;
- public health.

1.2.1 Health and social services establishments

The establishments constitute the foundation of the public network. For the citizens, they are the most visible representation of the health and social services network. At the present time, the network is made up of four types of establishments: local community services centres, social services centres, reception centres and hospitals.

Certain modifications have become necessary. The categories of establishments must further reflect the changing needs of citizens and the services they require. They must also reflect the determination to define the establishments more in terms of the citizens and population to be served.

The mission entrusted to each category of establishment must also be redefined. To ensure continuity of services for their citizens, the establishments have gradually broadened their mission. All of them have thereby become an entry to the system and have increased their services in the community by the development of their intermediary resources or their own program of home care services.

Finally, it is vital to clarify and recognize the responsibilities of the network in matters of teaching and research.

In order to clarify the mission of the establishments, it is necessary to:

- review the categories of establishments;
- tighten up the mission of the establishments;
- distinguish university hospital and university institutes;
- specify the functions of intermediary resources and their affiliation with the establishments.

Reviewing the categories of establishments

The changes and magnitude of the needs of the elderly who have lost part of their autonomy and the needs of young people in difficulty make it necessary to review three of the four categories of establishments in the network in order to better meet the needs of these groups of citizens.

Homecare reception centres and extended care hospital centres both have as their main role the providing of accommodation for persons with diminished autonomy. Their clienteles are more and more alike and call for similar facilities and personnel. The mechanisms for admission to the two categories have been unified. To promote flexibility and continuity of care, a single category of establishment must be created.

The difficulties faced by young people in society have become increasingly significant. Since the adoption of the *Young Offenders Act* and the *Youth Protection Act*, the social services centres have devoted an increasingly large proportion of their resources to this type of clientele. It now appears advisable to concentrate the mission of the social services centres on meeting the needs of the young people for whom these laws were required.

To this end, the Minister intends to:

- **amalgamate the residential centres and extended care hospital centres into a single category of establishment: residential and extended care centres;**

- **concentrate the mission of the social services centres on the protection of children and young people; to this end, set up a child and youth protection centre.**

Therefore, the Minister intends to have the following five categories of establishments recognized in the Act:

- **LOCAL COMMUNITY SERVICES CENTRES;**
- **HOSPITALS;**
- **REHABILITATION CENTRES;**
- **RESIDENTIAL AND EXTENDED CARE CENTRES;**
- **CHILD AND YOUTH PROTECTION CENTRES.**

Tightening up the mission of the establishments

The present *Act respecting health and social services* defines the mission of the establishments in terms of all the services, clienteles and facilities each category of establishment can cover. An establishment then has the liberty of delimiting its specific mission without necessarily having to fulfill every aspect of the mission allowed its category of establishment.

This broad definition of the mission of the various categories of establishments has enabled each of them to adjust its own mission to compensate for the absence of resources in its territory. Establishments have thus been able to make up for a lack of rehabilitation centres or a shortage of professionals in private practice in the community. Furthermore, such adjustments might have been particularly necessary at a time when the CLSC network was not yet completed.

This flexibility in the definition of mission has certain effects, not all of them positive. In fact, some establishments, without any consultation or coordination, broaden their mission to such an extent that overlapping and duplication of services arise.

In order to carefully delimit the mission of each establishment, the Minister intends to:

- **stipulate in the Act only the essential and distinctive functions of each category of establishment;**

- **define mission in terms of citizen groups to be served and services to be offered;**

- **retain the CLSC as the front-line public establishment;**

- **consolidate accordingly the role of other categories of establishments as specialized service providers, receiving their clientele by referral.**

The role of the CLSC as the front-line public establishment should take into account services of the same kind already offered by other resources in the community, such as a private practice or even another public establishment. Thus, it should never be a question of developing 24-hour-a-day emergency services in a CLSC when the hospital in the area already offers them.

On the other hand, an establishment may, if need be, assume mandates other than those expressly stipulated in its mission. However, it may not make such a decision by itself. Granting an establishment additional mandates will stem from the needs of the community and will be agreed upon in collaboration with the partners concerned at the regional and subregional levels.

Therefore, the Minister intends to define as follows the mission of each category of establishment.

Local community services centres (CLSCs)

The local community services centre is an establishment that offers the people of a specific area standard health and social services of a preventive or curative nature, and rehabilitation and integration services.

To that end, the centre ensures that the persons requiring such services for themselves or their families are reached, that their needs are assessed, and that the services required are provided within its facilities, at school or at home, or, if necessary, that they are referred to the hospitals, centres, organizations, or individuals most likely to assist them.

Hospitals

The hospital is an establishment that offers specialized medical treatment and diagnostic services.

To that end, the hospital receives, primarily by referral, persons who require such services, ensures that their needs are assessed, and that the services required are provided within its facilities, or, if necessary, that they are referred to the hospitals, centres, organizations, or individuals most likely to assist them.

Hospitals belong to one of the following categories:

- general and specialized care hospitals;
- psychiatric care hospitals.

Rehabilitation centres

The rehabilitation centre is an establishment that offers adaptation, rehabilitation, or social integration services for persons who, because of physical or intellectual impairment, personality, psychosocial or family difficulties, or drug addiction, require such services, as well as companion and support services for the families and friends of such persons.

To that end, the centre receives, by referral, young people who have adjustment difficulties and persons with impairments, and, primarily by referral, drug addicts and young mothers who have adjustment problems; it ensures that their needs are assessed and that the services required are offered within its facilities or in their own milieu, whether at school, at work or at home.

Rehabilitation centres belong to one of the following categories, depending on the clientele they serve:

- rehabilitation centres for persons with an intellectual impairment;
- rehabilitation centres for persons with a physical impairment;
- rehabilitation centres for drug addicts;
- rehabilitation centres for young persons who have adjustment difficulties;
- rehabilitation centres for young mothers who have adjustment problems.

Residential and extended care centres

The residential and extended care centre is an establishment

that offers a temporary or permanent substitute living environment, lodging, assistance, support and supervision services, as well as rehabilitation services, and psychosocial, nursing and medical care for adults of major age who, because of their loss of functional or psychosocial autonomy, cannot remain in their natural living environment, despite the support of those close to them.

To that end, the centre receives such persons by referral, sees to it that their needs are periodically assessed and that the services required are provided within its facilities or in a day centre.

Child and youth protection centres

The child and youth protection centre is an establishment that offers in its region the psychosocial services required by a young person under the *Youth Protection Act* or the *Young Offenders Act,* as well as child placement and family conciliation services, and expert assistance at the Superior Court in matters of child custody, adoption and the search for biological parents.

To that end, it provides reception services after a report or referral, situation assessment, expert advice and guidance; it takes charge of the cases of such young people either directly or by referring them to the centres, organizations or persons most likely to assist the young people and their families.

This reorientation of the social services centres necessarily implies that the services previously administered by such centres will be offered by other categories of establishments. This will be true, in particular, of social services for families, adults, elderly persons, Amerindians, refugees, and school children, which will be provided by the CLSCs. It will also be true of social services in an institutional setting, for which each of the establishments concerned will be responsible.

Distinguish university hospitals and university institutes

Although the basic raison d'être of the establishments consists in providing health and social services for the population, their role in teaching and research is indispensable for the realization of that mission.

However, the establishments in the network are in very different situations in regard to both their degree of participation in teaching and research and the support and recognition they enjoy for their participation.

In the health sector, there are too many university hospitals, with the following consequences: a proliferation of places dispensing ultraspecialized services, which does not always make it possible to produce the volume of services required to assure quality; a dispersal of students, which obliges each of them to shoulder a relatively heavy burden in duty hours; an absence of a critical mass of teaching staff capable of adequately supervising the students.

For the social services sector, it has not been possible to find an appropriate formula despite the determination to develop research and the expertise acquired in certain fields. Québec must, however, face major social problems such as family violence, child neglect, abuse of the elderly, etc.

The Ministry is confronted with two different problems. It must both rationalize the number of university hospitals in the health

sector and promote the emergence of university institutions in the social sector.

To this end, the Minster intends to:

- **reserve the designation of university hospital for a limited number of hospitals that fulfill the following functions:**

  - **dispensing of specialized and ultraspecialized services in a number of medical specialties;**
  - **medical education in a number of medical specialties;**
  - **research;**
  - **evaluation of medical technologies;**

- **introduce the title of university institute for establishments that act in a limited number of fields, but take part in the following functions;**

  - **dispensing of specialized services;**
  - **teaching;**
  - **research;**
  - **evaluation of techniques and technologies.**

- **promote the creation of university institutes in fields related to social problems;**

- **enable any establishment to obtain university affiliation as an affiliated centre.**

Specify the functions of intermediary resources and their affiliation with the establishments

The establishments increasingly call upon non-institutional placement services to obtain support services for children, adults and elderly persons. These resources lie half-way between an institutional setting and the natural environment of the person, hence their name, intermediary resources.

The development of such services has taken place in a disorganized manner. There have been as many as 18 different names for this type of service, the best known being group homes, pavilions and foster families. It must be recognized that the diversity of these resources reflects real needs. Their development fits in with Ministry orientations advocating that, in the interest of the clientele, institutional stays must be as short as possible, postponed or avoided.

However, a number of corrective measures are necessary if intermediary resources are to be used to the full to implement the policies pursued. The means of access to such resources are not clear. The role of the establishments is ambiguous as well and does not take into account the mission entrusted to the various categories of establishments. Coordination between establishments has so far been wanting. The result is friction and, frequently, a poor evaluation of the capacity of various communities to accommodate intermediary resources. Lastly, isolated initiatives in the development of these resources have produced disparities in financing and inequities in the rate of remuneration applied for similar services.

To ensure that establishments can adapt their services and adjust their measures in terms of the citizen's needs, the Minister intends to:

- **consider an intermediary resource any resource developed, controlled and financed by a public establishment with a view to maintaining and integrating persons in the community and administering**

residential services and support or assistance services in terms of their needs;

- **entrust the establishment with the function of managing these resources on the same basis as other services they provide and in terms of regional service organization plans determined by a regional board;**

- **ensure that a person is placed in an intermediary resource only if the support provided by his family or those close to him is insufficient to meet his needs in his natural environment;**

- **reserve exclusively for child and youth protection centres the power to recruit a family type resource for the placement of children;**

- **develop a list of intermediary resources and establish graduated rates of remuneration in terms of the intensity of service provided.**

Therefore, the Minister also intends to:

- **entrust the regional board with the following mandate:**

  . **determining the criteria for accrediting intermediary resources in its region;**

  . **establishing, for its region, the means of access to intermediary resources and instituting for that purpose regional placement committees by clientele (children, adults, elderly persons);**

  . **identifying the establishments that can use intermediary resources in the context of regional services plans;**

- **entrust the establishment with the mandate to:**

  . **recruit intermediary resources;**
  . **ensure follow-up of users of the services offered by intermediary resources;**
  . **subsidize these resources in line with the rates of remuneration established by the Ministry.**

1.2.2 Review of the organization of public health

In the wake of the reform of the 1970s, public health was organized around 32 community health departments. It then underwent major development. Expertise in Québec has been consolidated in particular as a result of the creation of university departments of social and preventive medicine which offer training toward a specialist certificate or a master's degree in community health.

In line with expectations, public health was brought closer to the clinical milieu. In this regard, the integration of the community health departments with hospitals has reached its objectives. Public health activities have proliferated, stimulated by the vitality of community health departments. They have also diversified to cover the functions of surveillance and the monitoring of the population's health, promotion and protection, as well as prevention of health problems.

Although it has had positive effects over the past 20 years, this organization of public health must now be revised for a number of reasons.

Promotion and prevention activities cannot be the responsibility of a single component in the network. The approaches on which they are based must permeate the entire health and social services network. Development of these activities and approaches might be impeded by concentrating them only in community health departments. Furthermore, such a concentration could lead to a decrease in the responsibility of other components with regard to the health and well-being of the people they serve. However, it does appear to be fundamental to maintain and consolidate centres of expertise to stimulate and support the development of promotion and prevention activities and approaches throughout the network.

Diversification of the activities carried on by community health departments has had as a major consequence the gradual abandonment of more traditional public health concerns: infectious diseases, environmental health and occupational health. However, various problems related to these fields are on the upswing. Québec must resolutely tackle these specific problems.

The organization of public health into 32 departments, without formal lines of authority or coordination, certainly merits improvement. It has led to a dispersal of expertise, a scattering of efforts, an absence of clear, common priorities, and difficulties in ensuring collaboration in critical situations. Nor has the Ministry fully assumed its responsibilities, leaving the community health departments without real direction.

The distance of public health representatives from the decision-making structures of the network, both regional and central, has meant that the approach by population segment has not been able to influence decisions as it should, particularly with respect to the identification of priorities, the choice of measures and the allocation of resources.

And the amounts allocated to public health are not fairly distributed throughout Québec. Some regions scarcely have the resources necessary for maintaining the minimum expertise in public health.

In order to review the organization of public health, the Minister intends to:

- **prepare a comprehensive public health program covering all the activities and resources granted in the fields of infectious diseases, occupational health and environmental health;**

- **appoint a provincial public health director in the Ministry, with the rank of deputy minister, responsible for the following five functions:**

  . **informing the population of its state of health, high-priority problems, risk factors, high-risk groups and measures considered most effective;**

  . **developing the appropriate strategies for the protection of public health;**

  . **developing expertise in health promotion and prevention, and integrating it into the Ministry's programs;**

  . **administering the public health program;**

. **compiling and keeping up to date the information necessary for carrying out his functions, including the results of analyses prescribed by law conducted in public or private laboratories.**

- **set up and coordinate a provincial network of centres of expertise in the following areas of public health: infectious diseases (including STDs and AIDS), environmental health, occupational health, health promotion and accident prevention;**

- **perform a gradual interregional reallocation of resources reserved for public health.**

To ensure better coordination at the regional level, the Minister intends to:

- **entrust management of the public health program to the regional board and arrange for the board to assume the functions relating to the various programs: establishing priorities, deciding on the organization of services in the territory, allocating resources, and monitoring their efficient use;**

- **ask the regional board to set up a regional public heath directorate and hire a public health director who will personally assume responsibility for the following three mandates:**

  . **informing the public of its state of health, high-priority problems, risk factors, high-risk groups and measures considered most effective;**

  . **developing strategies and taking the appropriate measures to ensure protection of public health, in accordance with the provisions of the *Public Health Protection Act;***

  . **assuring development of expertise in health promotion and in prevention in order to integrate this perspective into all the programs assigned to the regional board;**

- **make this director responsible:**

  . **to the Minister, for any matter relating to action in emergencies or situations involving an immediate threat to public health;**

  . **to the regional board, for any matter relating to the knowledge and monitoring of health services or any other mandate he may be entrusted with;**

- **ensure that the current staff of the community health departments remain in the network's establishments, by being attached administratively either to the public health departments under these establishments or to the regional boards;**

- **abolish in the Regulation under the *Act respecting health and social services* the concept of community health department in hospitals.**

1.2.3 Recognition of the contribution of community organizations

Today community organizations contribute to the direct dispensing of services and the strengthening of community ties. They revitalize and diversify approaches and means of action. In so doing, they prove

particularly good at meeting new needs. The extent, quality and originality of their activities are such that it is no longer possible to interpret health and well-being solely from the perspective of public measures.

Moreover, public services cannot and should not claim to satisfy every need. Apart from the services rendered by the establishments in the network, the communities and the users comprising them are in the best position to identify needs that are not being met and take the initiative to fulfill them. In this regard, the development and diversity of community organizations are an indication of the dynamism of Québec society.

The orientations of the Ministère de la Santé et des Services sociaux in matters of social reintegration, maintenance at home, and mental health recognize the importance of the contribution of community organizations and the need to support them. In spite of everything, the community organizations remain peripheral to the public network. The means made available to them are perceived as too modest. Moreover, public financing of community organizations always raises the question of the balance to be established between respect for the autonomy of the subsidized organizations, on the one hand, and their obligation to render an account of the use made of amounts received, on the other.

In order to recognize the contribution of the community organizations working in the health and social services sector, it is necessary to:

- specify their status in the Act;
- encourage their participation in decision-making and consultation;
- assure appropriate financing;
- evaluate their activities in light of the level of funding received.

Status

The Act must ensure that the contribution of community organizations is recognized and that they have the freedom to define their action. To that end, the Minister intends to:

- **define in the Act community organizations as groups that:**
  - **freely choose their orientations, policies and approaches;**
  - **carry on either volunteer activities or partly remunerated but non-profit activities in the health and social services field;**
  - **have a board of directors a majority of whose members are citizens or members of the community.**

Participation in decision-making and consultation

Legal recognition is not sufficient to ensure that the points of view of community organizations are taken into account in the preparation and implementation of programs and services. This is nevertheless one of the essential conditions for assuring complementary and joint action. Therefore, the Minister intends to:

- **reserve 20% of the seats on the board of directors of the regional board and at the regional assembly for representatives of the community organizations;**
- **require that regional boards make room for the community**

organizations within the consultative structures for planning and organization of services in their territory;

- **assure the community organizations of a place on ministerial committees and in province-wide consultation mechanisms set up in fields where the specific competence of the organizations must be called upon;**

- **provide for financial support for the participation of community organizations in these bodies.**

Appropriate financing

The means of financing community organizations are defined in terms of the manner in which their action complements that of the network, a regionalized budgetary allocation and the need to relax financing rules. To that end, the Minister intends to:

- **entrust the regional board with the responsibility to finance, within a three-year planning perspective, community organizations carrying out activities in the health and social services field in the region (organizations offering services, assistance or support, promotion, outreach, education and the defence of rights);**

- **retain the direct management of the community organization support program until April 1, 1992, or until such date as determined by the Minister;**

- **associate the exercise of this function by the regional board with a protective clause at least equal to the present total level of financing granted community organizations in its region, valid for five years or until the Ministry approves a regional plan for the organization of services;**

- **prohibit the signing of service agreements containing financial clauses between community organizations and establishments in order to safeguard the freedom of action and community character of these organizations;**

- **keep for the Ministry the responsibility of financing provincial associations and community organizations whose activities are province-wide in scope in the fields of social development, improvement of living conditions, prevention and health promotion, or whose activities meet new needs, take new approaches or target particular groups not covered by the various programs entrusted to the regional authority.**

To promote the development of community organizations that act in the field of health and social services, the Minister deems it necessary to:

- **increase by $8 million a year for five years, that is from $50 million to $90 million, the total amounts allocated to community organizations within the framework of a budgetary allocation by program;**

- **propose to the Minister of Finance that persons who make a financial contribution to community organizations be granted a tax deduction greater than their contribution in order to facilitate fund-raising by these organizations.**

Evaluation of activities in light of the level of funding received

The community organizations must account for the use of the public funds they are granted. The evaluation of their activities must also be in line with the subsidies received. An organization that receives $3,000 cannot be expected to provide a full range of information. On the other hand, when an organization receives public financing of the order of $200,000, the situation is fundamentally different. So the Minister intends to:

- **ask community organizations to make a report on their activities to their members at an annual meeting, and to the subsidizing authority;**

- **develop, in collaboration with associations of community organizations, an evaluation grid to be based on the various types of community organizations and the level of financing received.**

1.3 Granting the establishments real latitude

Just as the mission of the establishments needs to be clarified, it has become necessary to give local decision-makers the maximum latitude in the management of resources that enable them to fulfill their role.

The centralization of power in Québec has placed the establishments in the situation of carrying out rules dictated centrally. These rules rapidly stifle any leeway. The directives governing the management of human, material and financial resources have become restrictive for the establishments. They impede productivity and lead to bureaucratic activities whose utility and objectives are debatable. The quality of participation and even citizens' interest in participating are poorly served in such a context.

An attendent phenomenon is that the establishments are compelled to maintain structures whose composition and mandate are defined in the Act. This is particularly true of structures of an advisory nature, such as the committees of physicians, dentists and pharmacists, the clinical personnel advisory councils or the administration advisory committees.

These provisions sometimes fail to take into account the diversity of the establishments, they give preference to the medical or hospital model and, in any event, they prevent establishments from developing the management tools and mechanisms that would be better adapted to their particular situation.

Questions also need to be asked about the lack of precision surrounding physician-establishment relations, in particular because the physicians are so essential to the mission of the establishments. This shortcoming affects the availability of clinical medical services and the possibility of involving physicians in more administrative tasks.

It appears normal and necessary that the physician's status of free entrepreneur, without obligations but enjoying privileges on the individual level, should evolve towards relations with his place of work that guarantee the availability of clinical services and medical expertise wherever required. The situation in which a physician enjoys individual privileges but has only collective obligations must be corrected. For example, in the case of university hospitals, the collective obligation of all physicians to

participate in training and research should have a concrete impact on the daily activities of each of them.

In order to grant real latitude to establishments and local decision-makers, it is necessary to:

- simplify current regulations;
- allow for better adapted internal structures;
- aim for better integration of physicians into the establishment.

1.3.1 Simplified regulations

To lighten the burden of current regulations, the Minister intends to:

- **immediately review all the current regulations, including management standards and practices regarding human, financial and material resources, by creating for that purpose a task force consisting of representatives from the Ministry, the regional authorities and the establishments.**

1.3.2 Better adapted internal structures

To allow for better adapted internal structures, the Minister intends to:

- **remove from the current legal framework several of the provisions relating to the internal structure of establishments, their mandate and their composition, in particular those regarding the clinical personnel advisory council, the administration advisory committee, the director of professional services and the director of nursing care;**

- **enable establishments to maintain or replace these structures by others whose mandate and composition better reflect their own particular characteristics;**

- **maintain the existing structures of establishments for a maximum of three years after the enactment of the legislation, to enable them to review existing structures and file their organization plan with the regional board.**

1.3.3 Greater integration of physicians

In order to make possible better integration of physicians into the establishment, the Minister intends to:

- **ask the boards of directors of the establishments concerned to:**

  - **include in the resolution assigning or renewing status or privileges for a physician, the obligations regarding his participation in:**
    - **clinical activities in the establishment, including ward duty;**
    - **professional, scientific and medico-administrative committees;**
    - **teaching and research activities where applicable;**

  - **establish these obligations in conformity with the mission of the establishment and the regional service organization plan;**

  - **obtain from the physician his written commitment to respect these obligations;**

- **make the maintenance of the status and privileges of the physician subject to his respecting the commitment he has made;**

- **adopt the principle of compensating physicians for their participation in medico-administrative activities and evaluate the means of applying it.**

2. THE CITIZEN AT THE HEART OF DECISION-MAKING

The active participation of all citizens is deemed essential for the network to run smoothly. This supposes that citizens are able to discuss orientations, priorities, and users' needs, and work out how these should be met. However, three conditions must be respected: the citizens making decisions must be fully aware of their responsibilities, have a range of resources at their disposal to meet clientele needs, and assume their proper place within the decision-making structures.

To return citizens to the heart of decision-making, we must:

- entrust the boards of directors with responsibilities, duties and powers;
- increase the complementarity and consultation between establishments;
- ensure that the boards of directors are made up for the most part of citizens.

2.1 Entrusting the boards of directors with responsibilities, duties and powers

Many board members have wondered what their mandate actually consists of since responsibilities at present are entrusted more to the internal structures of an establishment than to its board of directors. The legislation defines the categories of establishments, makeup of the boards of directors, internal structures and their mandate, and functions of the executive director, director of professional services, nursing director, and clinical department heads, but does not specify its expectations with regard to boards of directors.

If it refers to them at all, it is in such vague terms that it is difficult to perceive the balance between their responsibilities, duties and powers.

For this purpose, the Minister intends to:

- **define in the legislation the responsibilities, duties and powers of the boards of directors of establishments and regional boards.**

2.1.1 Establishments

The Minister intends to entrust the boards of directors of establishments with the following *responsibilities:*

- **ensure that accessible, personalized and continuous services are provided, that these are quality services on the scientific, human and social levels, and that they are offered with a view to the respect of fundamental human rights in order to meet users' needs in matters of health and well-being;**

- **see to the general coordination of internal and external services, including those of intermediary resources, offered by the establishments they administer, in light of:**

- **particular geographical, linguistic, sociocultural and socioeconomic characteristics of users;**
- **mission of the establishments;**
- **human, material and financial resources at their disposal;**
- **regional service organization plans and medical staffing plans.**

The Minister intends to assign the following *duties* to the boards of directors of establishments:

- **establish, update and implement priorities and orientations for the establishments they are responsible for, as regards:**
  - **health and social needs to be met;**
  - **clienteles to be served;**
  - **services to be offered;**
- **establish, see to the implementation of, and update an administrative, professional and scientific organization plan that provides for, among other things, formal evaluation and improvement mechanisms with regard to:**
  - **the relevance, quality and effectiveness of services provided;**
  - **user satisfaction, respect of user rights, and mechanisms for handling complaints;**
  - **efficient use of financial resources;**
  - **the participation, motivation, enhancement and development of human resources, and the upgrading of their skills;**
- **inform the public and the regional board, and be accountable to them for their administration.**

However, in hospitals, the Minister intends to:

- **maintain a council of physicians, dentists and pharmacists which, under the authority of the executive director or his representative, will be responsible for:**
  - **assessing the relevance, quality and efficiency of medical, dental and pharmaceutical services provided in the hospital;**
  - **evaluating and maintaining the competence of the physicians, dentists and pharmacists who work in the hospital;**
  - **giving its opinion on the rules governing medical and dental care and pharmaceutical services in the hospital;**
  - **formulating an opinion to the executive director or his representative on any other matter brought to its attention;**
- **set up a council of nurses which, under the authority of the executive director or his representative, will be responsible for:**
  - **assessing the relevance, quality and efficiency of nursing care provided in the hospital;**

- **evaluating and maintaining the competence of the nurses working in the hospital;**

- **giving its opinion on the nursing care rules applicable in the hospital;**

- **formulating an opinion to the executive director or his representative on any matter brought to its attention.**

To ensure that there is consultation between these two councils, the Minister intends to:

- **include the chairperson of the council of nurses or her representative on the executive committee of the council of physicians, dentists and pharmacists;**

- **include the chairperson of the council of physicians, dentists and pharmacists or his representative on the executive committee of the council of nurses.**

The Minister intends to entrust the boards of directors of establishments with the following *powers:*

- **create any mechanisms needed to achieve their ends and, accordingly, adopt the regulations and resolutions they deem necessary;**

- **hire the executive director, ratify the appointment of senior executives, and appoint physicians on the recommendation of the executive director;**

- **allocate the financial resources to the establishments and related intermediary resources.**

2.1.2 Regional boards

The Minister intends to entrust the boards of directors of regional boards with the following responsibilities:

- **define and direct all actions of their region towards improvement of the health and well-being of the population, and, to this end:**

  - **encourage the highest possible level of participation in public meetings and in the election of members to the boards of directors of establishments in the network;**

  - **act as leaders in the regional planning and organization of the health and social services network;**

  - **ensure cooperation and coordination with the other sectors of community life that may have an impact on health and well-being;**

  - **if need be, obtain interregional cooperation;**

  - **coordinate and channel the contributions of the various actors, whether they be public, private or community;**

  in light of:

  - **the special linguistic and cultural features of the population and the sub-regional and socioeconomic characteristics of the region;**

- **the human, material and financial resources they are entrusted with.**

The Minister intends to assign the following *duties* to the boards of directors of the regional boards:

- **establish, update and implement priorities and orientations for the regional board with regard to:**
  - **the health and well-being needs to be met;**
  - **the clienteles to be served;**
  - **the services to be offered;**
- **prepare the regional service organization plans designed to clarify the contribution of private practices, establishments and organizations in a given territory to the attainment of health and well-being objectives, and submit them to the Minister for approval;**
- **establish and update an administrative organization plan that sets out, among other things, the various administrative units of the board and their functions, and see to the implementation of this plan;**
- **be accountable for their administration to the regional assembly and the Minister of Health and Social Services and, to this end, draw up and submit an annual report on their activities.**

The Minister intends to entrust the boards of directors of the regional boards with the following *powers:*

- **create any mechanism required to meet their ends and, for this purpose, adopt the regulations and resolutions they deem necessary;**
- **allocate human, material and financial resources to the establishments and community organizations in an equitable manner;**
- **hire the executive director and ratify the appointments of the senior executives;**
- **delegate part of their responsibilities to an executive committee or the executive director.**

2.1.3 Position of the executive director

This redefinition of the role and functions of the regional and local boards of directors is intended to give them more latitude. To confirm their new responsibilities, allow them to render their decisions executory, and count on a person responsible for executing these decisions, the Minister intends to:

- **entrust the executive director with the following functions:**
  - **execution of the decisions of the board of directors;**
  - **authority over all internal structures and, in the case of the establishments, over those provided for in the administrative, professional and scientific plans;**
  - **accountability to the board of directors for any matter relating to the operation and administrative, professional and scientific management of the establishments;**

  - **transmission to the board of directors of any information requested by the latter;**

- **create, in conjunction with the École nationale d'administration publique and associations of establishments, a mechanism for certifying the competence of persons wishing to apply for a position as executive director of an establishment or regional board;**

- **require that the boards of directors make this certification of competence an essential condition for the position of executive director;**

- **grant the executive directors currently in position the possibility of priority qualification.**

2.2 Increasing complementarity and consultation between the establishments

There is a quite obvious lack of complementarity and consultation between the establishments within the network. We have but to look at the parallel development of day hospitals and day centres attached to extended care hospitals and reception centres respectively; that of home care hospitals and intensive home care services offered by short-term care hospitals and CLSCs respectively; that of foster families for adults suffering from psychological problems reporting to social service centres and group homes reporting to psychiatric hospitals. In short, each entity wants to organize all the services to meet all the needs of its clientele. A joint approach is required, in particular for specific clienteles such as seniors, young people or the disabled.

Other matters to be examined include the high levels of supervisory personnel in establishments and the lack of consultation.

To favour complementarity and consultation between public establishments and greater efficiency in the use of supervisory resources, the Minister intends to:

- **set up unified boards of directors grouping more than one establishment according to the following terms and conditions:**

  - **one board of directors per regional county municipality (RCM) territory for all the residential and extended care centres that have fewer than 50 general and special care beds;**

  - **one board of directors per region for youth protection centres and for rehabilitation centres for young people or young mothers with adaptation problems;**

  - **one board of directors per region for each of the following categories of rehabilitation centres: those for the mentally disabled, those for drug addicts, and those for the physically disabled;**

- **grant the regional authorities a period of one year to propose particular board arrangements to take the geographical, cultural and linguistic features of their region into account;**

- **maintain individual boards of directors for:**

  - **CLSCs;**
  - **hospitals;**

- **residential and extended care centres with more than 50 general and special care beds;**
- **university hospitals;**
- **university institutes.**

2.3 Boards of directors consisting for the most part of citizens

Citizens are largely in the minority on boards of directors of establishments. Discussions focus all too frequently on the concerns of service providers, who regard the board of directors as a forum for the expression of their interests.

This results in a health and social services system which is self-contained, and which does not encourage citizens to get involved. It is rather impermeable to the efforts made by citizens to find answers to their needs and participate in decision-making. The system cannot continue to develop detached from the citizens' awareness of their own needs.

Most of the seats on boards of establishments must therefore be given to citizens who do not work within the health and social services network. This principle does not deny the necessity of keeping a place for staff, whose expertise is essential to the organization and operation of the services network. Room must also be made for representatives of other sectors of activity, so as to develop the multisectorial action that is vital for improvement of the health and well-being of the population. Finally, the boards of directors of establishments must respect the rights and prerogatives of the corporations which own the capital assets.

To ensure that boards of directors are made up for the most part of citizens, the Minister intends to:

- **allocate the seats available on the boards of directors of establishments as follows:(1)**
  - **four representatives of the public elected during the annual meeting of the establishment or establishments involved, with the exception of the CLSCs, which will have five representatives;**
  - **three staff representatives including, in the case of a hospital, a physician and a nurse;**
  - **two representatives appointed by the user committee or committees provided for in certain categories of establishments;**
  - **three representatives appointed by the corporation or corporations actually owning the capital assets, where applicable;**
  - **a representative appointed by the foundations attached to one or more establishments, where applicable;**
  - **two representatives appointed by the university for university hospitals and university institutes, one of whom is to be associated with the teaching sector, and the other the research sector;**
  - **two representatives appointed by the school milieu and the justice milieu respectively for the boards of directors with which child and youth protection centres will be affiliated;**
  - **a representative appointed by the school milieu for rehabilitation**

(1) The makeup of the boards of directors is illustrated in a table in Appendix 1.

centres that provide services for young people;

- **two members coopted by representives already elected or appointed members of the board;**

- **the executive director of the establishment or establishments, as the case may be, with voting rights.**

Staff representatives may not serve as chairperson of the board or hold the position of officer. In addition, staff may not vote in the annual meeting held to elect representatives of the public. Finally, they may not hold any positions on the board of directors of their establishment, other than those specifically reserved for their representatives.

On the regional level, the Minister intends to:

- **create a regional assembly made up of citizens in each region;**

- **entrust the regional assembly with the following responsibilities:**

  - **elect among its members the persons who will make up the board of directors of the regional board;**
  - **approve regional priorities;**
  - **approve the annual activity report;**

- **ensure that it is made up solely of persons who do not receive remuneration from the health and social services network, except if elected by universal suffrage, and who are representative both of the entire territory and of the various sectors involved in the health and welfare sector;**

- **set the maximum number of members of this assembly at 150 and allocate the seats as follows:(1)**

  - **20% of the seats will be reserved for elected municipal representatives of each RCM in the region;**

  - **20% of the seats will be assigned to representatives of socioeconomic groups and other spheres of activity (e.g. justice, environment, recreation, education and housing) from each RCM;**

  - **40% of the seats will be held by representatives of the public and user members of the boards of directors of each category of establishment and by representatives of private establishments;**

  - **20% of the seats will be given to representatives of the public and user members of the boards of directors from the various types of community organizations;**

- **establish the makeup of the board of directors of the regional board as follows:**

  - **20 members elected by the regional assembly based on the same proportion as the groups represented on the regional assembly;**

  - **one executive director appointed by the board of directors of the regional board, with voting rights.**

(1) The size of the regional assembly provided for in each region is illustrated for information purposes in a table in Appendix 2.

3. CITIZENS ACCOUNTABLE FOR THEIR DECISIONS

Because health care establishments obtain their financing from public funds and because the services offered are intended for the community, citizens who sit on a board of directors will readily understandable that they are accountable for their actions.

Their accountability and especially the forms taken by such accountability have not been extensively developed to date, despite the importance of the responsibilities and amounts of money involved. The changes made by the reform call for reinforcement of this accountability for a number of reasons.

The new imperatives of efficiency in the management of resources are in themselves a primary reason. Secondly, local decision-makers will enjoy increased latitude as a result of fewer regulations and a looser management framework.

But there is more: if the Québec system embarks on a process of decentralization, this will not be accompanied by the implementation of a regional authority elected by universal suffrage and entrusted with taxation authority. This deliberate choice leads to another as a consequence: at both the local and regional levels, the members sitting on the decision-making boards will have to be subject to specific restrictive accountability mechanisms. They will therefore be required to account to the public and to the higher authority from which they obtain their financing for the amounts spent and action undertaken.

3.1 Boards of directors of establishments

To translate this dual accountability of the boards of directors into facts, the Minister intends to:

- **with regard to the public:**
  - **open the sessions of the various boards of directors of the network to the public, subject to sessions behind closed doors under certain circumstances;**
  - **require the boards of directors of establishments to include a question period during their meetings;**
  - **maintain the obligation for the boards of directors of the establishments to report on their activities during the annual meeting with the public of their territory;**
- **with regard to the regional board:**
  - **require that all establishments file their annual activity reports with the regional board;**
  - **require that the establishments report on all matters relating to their management during an annual meeting held by the regional board.**

3.2 Boards of directors of regional boards

To translate the dual accountability of the boards of directors of the regional boards into facts, the Minister intends to:

- with regard to the public:
  - open the sessions of the boards of directors of the regional boards and debates of the regional assemblies to the public, subject to sessions behind closed doors under certain circumstances;
  - require the boards of directors to include a question period during their meetings;
  - require the boards of directors to have the priorities of their action plan and annual report approved by the regional assembly;
- with regard to the Ministry:
  - have approved by the Minister:
    - the plans in respect of the organization of their services;
    - the allocation of their resources;
  - submit their annual activity report to the Minister;
  - request that the National Assembly grant the parliamentary commission on social affairs the power to hear and make inquiries of the board of directors of a regional board and to invite the Minister of Health and Social Services to be present.

III. THE CITIZEN AS PAYER

It would be erroneous to claim that health and social services are free. One way or another, it is the citizens that always pay for services received, whether it be through their taxes, the premiums paid for private insurance or a direct contribution. Changes to health and services expenditures therefore involve primarily the citizen as payer.

Before presenting the orientations defined from the standpoint of the citizen as payer, it is essential, in light of the factors at stake, to properly present not only the facts and possible options, but also the criteria that prevailed in choosing such orientations.

1. THE FACTS

For the citizen as payer, there are positive and negative aspects to the facts relating to health and social services expenditures.

1.1 Per capita expenditures

The first positive aspect is that every Québec citizen spends less on average on health and social adaptation than people in the rest of Canada. Per capita expenditures are lower in Québec, both for expenditures paid through taxes (public expenditures) and for expenditures paid via the various sources of financing (total expenditures).

As an example, in 1987, total health expenditures per capita were $1,771 in Québec, $1,987 in Ontario, and $1,871 for Canada as a whole. Public expenditures per capita stood at $1,369 in Québec, $1,400 in Ontario, and $1,388 for Canada as a whole.

1.2 Rate of increase in expenditures

The second positive aspect relates to the rate of increase in expenditures, both total and public, which is lower in Québec than in the rest of Canada. Between 1984 and 1987, the average annual increase in total health expenditures was 7.7% in Québec, 10.9% in Ontario, and 8.7% for Canada as a whole. The rate of increase in public expenditures was 6.3% in Québec, compared with 10.7% in Ontario and 8.3% for Canada as a whole.

For the citizen as payer, the facts also include negative elements.

1.3 Expenditures in relation to GDP

The first negative aspect is that the share of the collective wealth spent on health and social services is higher in Québec. In 1987, the share of the gross domestic product allocated to health expenditures was 8.3% in Ontario and 8.6% for the rest of Canada, but 8.8% in Québec.

1.4 Expenditures in relation to other government expenditures

The second negative factor is that expenditures related to the health and social services sector increase at a more rapid rate than government expenditures as a whole. Between 1985 and 1990, the average annual increase in health and social services expenditures was 6.7% for the network of establishments and 8.9% for programs administered by the Régie de l'assurance-maladie du Québec. Government expenditures, for their part, rose at the rate of 5.9% a year. This trend is all the more significant as the share of expenditures

financed through public funds is higher in Québec. In 1987, the percentage of total health expenditures from public funds was 77.5% in Québec, 70.5% in Ontario, and 74.2% for Canada as a whole. However, this proportion has decreased in Québec in the past few years, while it has risen in the rest of Canada.

Nevertheless, the government spends an increasing portion of its budget on health and social services. In 1985-1986, this share was 28.6% of the budget, compared with 30.3% in 1989-1990.

1.5 Expenditures in relation to revenues

The third negative factor is that the foreseeable rate of increase in health and social services expenditures is 3.8% above inflation (CPI + 3.8%). This is higher than the projected increase in government revenues, which is expected to be 1.5% above inflation (CPI + 1.5%).

From 1985 to 1989, the financing of expenditures was sustained by a strong economic performance, which translated into an average annual growth of 4.1%. However, this growth is expected to slow down to approximately 2.5% to 3.0% in the next few years, which will translate into a reduction in the rate of increase of government own-source revenues. Moreover, the reduction in financial transfers from the federal government, in particular for health and post-secondary education, deprives the Québec government of hundreds of millions of dollars annually. By 1991-1992, Québec will have lost a total of over $1.1 billion since 1982 for the health sector alone.

When all is said and done, from the standpoint of the citizen as payer, it is not the level of expenditures or their rate of growth as such that raises concerns. The problem stems more from the fact that expenditures are high in Québec in light of the collective wealth and that they take up a greater and greater share of the government's budget. Moreover, the growth of expenditures related to the health and social services sector is incompatible with the budgetary objectives of the government.

2. OPTIONS

Citizens face a dilemma which stems from their dual situation as consumers and as payers. As payers, citizens require that the health and social services sector respect their ability and the government's ability to pay. As consumers, however, they require that additional resources be devoted to the health and social services sector, which must be in a position to meet their overall needs.

To reconcile these legitimate but contradictory points of view of citizens depending on their reactions as consumers or as payers, two methods are possible: reducing health and social services expenditures or increasing revenues. To reduce expenditures, the efficiency of the system must be increased or certain services must cease to be covered. To increase revenues, new fiscal measures must be resorted to or fees must be placed on services. These options are obviously not mutually exclusive.

3. DECISION-MAKING CRITERIA

Whatever the options selected, they must correspond to the objectives and values of Québec society. More specifically, they must correspond to the following for criteria:

- maintain the current equity, that is the fair distribution of risks and the financial burden among citizens;
- maintain the competitive edge of Québec;
- increase the effectiveness of the services network;
- contribute to attaining the government's budgetary objectives.

3.1 Maintaining the current equity

All citizens of Québec have access to health and social services without distinction based on their income or social situation. Financing the system directly out of the general revenues of the government has made it possible to equitably distribute the financial burden among the members of the community, from rich to poor, from those in good health to those suffering from health or social problems. Our current choices must preserve this fundamental acquired right.

3.2 Maintaining the competitive edge of Québec

Today economic development must obey the new rules imposed by the opening up of markets and globalization of the economy. In a number of sectors, Québec is in competition with its neighbours. It must therefore maintain competitive taxation. This is a primary rule, and an objective which is a priority for the government.

Québec must also sustain competition with regard to total health expenditures, whose increase would also harm the competitive capacity of Québec in economic terms. Since the total expenditures are assumed by the citizens in any case, such an increase would add to the financial burden of the government and the community. The experience in other countries have substantially fully demonstrated that withdrawal of the government from the financing of the health system translates into an increase in total expenditures. The transfer of government expenditures to individuals does not therefore constitute a solution in itself.

3.3 Improving the effectiveness of the services network

The measures chosen must not lead to the consumption of more costly services. The possibility of people being encouraged to waive preventive or ambulatory services in favour of an increased consumption of curative institutional services must be avoided. People must also be prevented from postponing consultation that is necessary, at the risk of aggravating their problems, and consequently, potential recourse to services that are even more costly.

3.4 Attaining the budgetary objectives of the government

The growth of the sector's expenditures must be contained, not only in light of the importance of the health and social services network in government expenditures as a whole, but also to ensure they are in line with the growth of government revenues.

4. ORIENTATIONS

To begin with, only measures designed to improve the effectiveness of the system will make it possible to maintain the competitive edge of Québec, increase effectiveness of the services network and preserve the concept of equity. However, they are not in

keeping with the budgetary objectives of the government in the short term.

However, the measures that may lead towards this objective, namely elimination of coverage and charging for services, do not fit in with the other three criteria. They are likely to reduce the effectiveness of the services network and to be socially inequitable: detrimental to disadvantaged groups and people who need services the most.

With regard to fiscal measures, they affect the fiscal competitiveness of Québec directly. On the other hand, they are equitable and allow the government to meet its budgetary objectives.

Everything considered, no one option meets all four criteria perfectly, and choices must therefore be made.

To make the concept of the citizen as payer central to the health and social services system, the Minister advocates the following orientations:

- citizens who get their money's worth;
- citizens who must assume the cost of services.

4.1 Citizens who get their money's worth

There is currently no way of ensuring whether the financial resources invested in health and social services are used as rationally or as judiciously as possible. It is quite obvious that improvements could be made and savings achieved, but more in the medium term than in the short term.

Various factors will for their part exert a strong upward pressure on costs. We have but to think of the aging of the population, catching up to be done as regards technological development and maintenance of assets, and certain emerging needs (AIDS, violence, homelessness). In light of this pressure, the Ministry believes that the rate of growth of the sector's expenditures cannot be brought down to that of other government expenditures. The government recognizes this fact and subscribes to the idea that health and social services must remain a priority. This ties in with the way of thinking of citizens themselves.

More specifically, the government intends to:

- **grant the Ministry, in principle, an average real growth equivalent to 3% of its budget over the next five years;**

- **approve measures having a financial impact prior to their implementation;**

- **take into account the economic climate, the budgetary policy and the ability to pay of the government.**

Moreover, the Ministry recognizes that it must contribute to attaining the balanced budgetary objectives of the government and that it can, by efficiency gains, facilitate attainment of this objective to which it subscribes. Accordingly, the Minister intends to:

- **maximize efficiency gains associated with the implementation of particular measures stemming from the reform.**

One of the intended goals of the reform is specifically to make the health and social services network more efficient in using resources and more effective in solving health and well-being problems.

Although the measures retained will not have any tangible effects for a few years, their

potential already appears considerable and likely to bring significant dividends to citizens wishing to get more for their money.

From this viewpoint, the Minister is firmly convinced that:

- the system must make results the focus of its objectives;
- resources must be allocated in terms of the population to be served and the performance of establishments;
- the nature and scope of insured services must be reviewed periodically;
- the increase in the number of physicians must be reduced to a rate compatible with the sociodemographic development of the population;
- the remuneration of physicians must be made more compatible with the practice in establishments.

In addition, the Minister intends to take action in order to:

- rationalize the implementation of health technologies;
- require the development of joint purchasing;
- curb the proliferation of services;
- prohibit double remuneration of medical staff;
- rationalize the operation of public and private laboratories.

4.1.1 Making results the focus of the system's objectives

The concept of services is at the heart of the development of the health and social services network. It is so central that offering more and more services, and better, more accessible and more continuous services, has become an objective in itself.

All groups, including professional associations, establishments, community organizations and unions, are asking for additional financial resources to meet this objective. The intention is laudable, but the objective itself is debatable since it loses sight of the basic concept of services: to solve the health and social problems of the population.

This leads to three consequences which certainly do not contribute to assuring citizens that resources invested are used as rationally as possible. First, there is no limit to the quantity of resources that can be invested to continually increase the accessibility to services, their continuity and their quality; the only remaining obstacle is the lack of money. In addition, there is no guarantee that this increase in services will contribute to further solving health and social problems. Finally, the network sees itself as the sole entity responsible for public health and social services. It all too frequently forgets the contribution of individuals, families, communities and other sectors.

The only way to curb these consequences is to modify the very dynamics of the system and to focus it in terms of the health and well-being problems to be solved rather than the services to be developed. Such an orientation necessarily requires

an appropriate epidemiological knowledge of these problems and actions for which the expected results are scientifically founded.

To make results the focus of the system's objectives, the Minister intends to:

- **in April 1991, make public a health and well-being policy that sets out:**
  - **objectives centred on the reduction of specific problems and the needs of particular clienteles;**
  - **the strategies to be favoured, including the recognition and support of the essential contribution of individuals, families and communities;**
  - **the means deemed most effective to achieve them;**
- **create a permanent health and social epidemiological investigation centre with a mandate to conduct surveys on the state of health and well-being of the Québec population, in conjunction with the organizations concerned;**
- **use research as an important lever for action, and consequently:**
  - **increase the share of the budget reserved for social research;**
  - **increase the efforts made with regard to evaluative, clinical and epidemiological research;**
  - **double the share of the network's budget earmarked for research, by increasing it from 0.4% to 0.8% of expenditures, based on a continuous progression, over the next five years;**
  - **increase the budget of the bursary researchers program of the Régie de l'assurance-maladie du Québec to 0.4% of the total compensation paid by the Régie to health care professionals during the previous year, as provided for in *the Québec Health Insurance Act.***

4.1.2 Allocating resources in terms of the population to be served and the performance of establishments

The current manner of allocating budgets is just as debatable. From year to year, establishment budgets are renewed and indexed without any question as to their historical bases and any comparison of the relative performance of the establishments.

Our allocation methods are still based on the provision of services, and not on the health and social needs and characteristics of the population to be served. As a result, the more equipment and service providers a territory has, the higher its budget.

The allocation of a health system cost, which consists in raising by 1% annually the operating budget of hospitals, illustrates this phenomenon very well. The amounts earmarked are strictly determined by the increase in services provided and increased use of high technology.

Evolution of the RAMQ budget provides another example, since it depends solely on the number of physicians and average income the government negotiates with them. This modus operandi is not without its consequences. Notwithstanding the

agreements negotiated with physicians, savings of $100 million could have achieved for 1990 alone if expenditures of the RAMQ medical services program had evolved since 1986 solely in terms of the growth and aging of the population rather than the increase in the number of physicians.

In addition, the allocation of resources may even implicitly encourage deviance. Considerable amounts have been allocated by the Ministry to establishments to meet certain deficits, without prior appraisal of the performance of these establishments in the use of resources already granted.

To correct the current deficiencies in the methods of allocating resources, the Minister intends gradually to:

- **with regard to regions:**
  - **allocate resources interregionally in terms of the population to be served rather than the number and characteristics of the service providers;**
- **with regard to establishments:**
  - **establish a means to measure the performance of establishments and revise their budgetary bases accordingly;**
- **with regard to physicians:**
  - **establish an annual closed budget for the RAMQ to cover the cost of medical services;**
  - **have this budget evolve in light essentially of the demographic characteristics and state of health of the public, rather than in light of the number of physicians and average negotiated income, as is the case currently.**

4.1.3 Reviewing the nature and scope of insured services

Programs that constitute the range of insured services are not called into question very frequently. However, these programs are very costly in some cases, and there is nothing to assure citizens that they meet their objectives.

The medication insurance program administered by the RAMQ has been the subject of numerous comments to this effect. Although it is true that it has enabled the most underprivileged to obtain the medication they need free of charge, it has also contributed to various phenomena such as overconsumption and, in some cases, abuse. Moreover, a large number of hospitalizations are caused by the abuse or misuse of medication. In addition, substantial savings could be achieved if the rate of growth of the annual increase in the average cost of medication by prescription (11.6% from 1985 to 1989) and the number of prescriptions by recipient (4.14% from 1985 to 1989) were reduced by 1%.

Furthermore, the lack of coordination between pharmacy departments and clinical departments in establishments often lead to a waste of medication and resources. Conversely, establishments that have integrated pharmaceutical and clinical functions more closely have shown a net improvement in this regard. The big winner is the user.

It is therefore normal and legitimate to raise the question of the effectiveness of the programs, their positive or negative effects, the rate of growth, their degree of use

and their relevance in light of the changing needs of the population.

To this end, the Minister intends to:

- **conduct a review of the various insured plans;**
- **undertake an examination of the medication insurance program administered by the RAMQ as early as next year;**
- **entrust the pharmacology advisory council with analysis of the use and prescription of medication, in particular with regard to the elderly;**
- **revise the methods used to set the price of medication paid to pharmacists;**
- **reinforce the clinical function of pharmacy departments in establishments and, even more so, in residential and extended care centres in order to prevent the excessive use of medication;**
- **request that CLSCs develop preventive activities with regard to the abuse of medication by the elderly, in particular those living at home.**

4.1.4 Reducing the increase in the number of physicians to a rate compatible with the evolution of the social and demographic characteristics of the population

We have seen that the number of physicians in Québec is rising three times as fast as the population, although Québec (along with British Columbia) already has more doctors per capita than any province in Canada. The costs associated with the presence of excess medical manpower, which increases year by year, are considerable.

In Québec, three categories of physicians can obtain access to medical practice: graduates from faculties of medicine in Québec, medical graduates from outside Canada or the United States, who request the status of immigrant or refugee, and foreign specialists recruited to meet the needs of outlying regions or to provide an expertise not available in Québec universities.

To reduce the increase in the number of physicians to the rate of growth of the population and the evolution of its health and social characteristics, the Minister intends to:

- **reduce the number of admissions to faculties of medicine from 575 to 560 as of next year, and revise this number every two years thereafter;**
- **reduce, among other things, the number of admissions of non-Québec students from 94 to 79;**
- **beginning in 1991, reduce the number of medical specialists recruited from abroad from 28 to 20;**
- **beginning in 1993, reduce the number of residencies for graduates of a faculty of medicine outside Canada and the United States from 35 to 16.**

4.1.5 Making the remuneration of physicians more compatible with the practice in establishments

The current remuneration method by the act is being called into question more and more frequently, especially since it provides an incentive for the production of increased, more costly services. However, there is no ideal means of remuneration that is able to meet the requirements of all types of practice: private doctor's offices and establishments, university hospitals and CLSCs.

However, this form of remuneration is incompatible with the simultaneous fulfillment of the three functions of university hospitals: the provision of services, teaching and research. The teaching and research functions adapt poorly to the current means of remuneration.

Corrective measures must therefore be applied to the method of remunerating physicians who practice in university hospitals. They must allow for a better balance in the fulfillment of the various functions related to this practice and adaptation of the remuneration method to various hospital and university settings in Québec. To correct these deficiencies, the Minister intends to:

- **implement, by April 1, 1992, a fixed fee basis for all physicians practising in university hospitals;**

- **define the terms and conditions for implementation in conjunction with the Fédération des médecines spécialistes du Québec, the Ministère de l'Enseignement supérieur et de la Science, faculties of medicine and university hospitals;**

- **grant faculties of medecine and university hospitals a period expiring on April 1, 1992 to agree on the terms and conditions for sharing the amounts collected from the Régie de l'assurance-maladie du Québec, the Ministère de l'Enseignement supérieur et de la Science, and the Fonds de la recherche en santé du Québec.**

These terms and conditions must enable all physicians practising in university hospitals to be paid in a way more compatible with the fulfillment of the functions of service provision, teaching and research, while respecting the user.

4.1.6 Rationalizing the implementation of health technologies

Health technologies have literally exploded over the past two decades. They have led to considerable progress in preventing and treating a number of diseases. Medical practice today is largely dependent on a range of complex technological means.

But technological development, in addition to the ethical problems it sometimes raises, generates significant costs. Before being disseminated, any technology must have proven its efficiency. It must then be made accessible and favour rational use.

The adoption of these principles has led to the creation of the health technologies evaluation council, which advises the Minister on matters touching the introduction, dissemination and use of technologies.

To rationalize the implementation of health technologies, the Minister intends to:

- **establish a development plan for ultraspecialized equipment for the whole of Québec;**
- **ask each regional authority to establish a three-year plan for investment in high technology;**
- **take measures to ensure that any equipment acquired by a health establishment without authorization is transferred by the Ministry to an institution where the need has been established.**

4.1.7 Requiring the development of joint purchasing

It costs $1.4 billion annually to purchase products that are consumed or used in the health and social services network. Only 30% of the potential joint purchasing programs have been developed. The force of the network's negotiation and buying power could represent additional annual savings of approximately $50 million.

To make utmost use of this buying power, the Minister intends to:

- **entrust the regional boards with the mandate to require establishments to form purchasing groups;**
- **require establishments to be members of these purchasing groups;**
- **set up a provincial purchasing mechanism for some types of ultraspecialized equipment.**

4.1.8 Curbing the proliferation of services

The health and social services network currently has few means to curb the proliferation of services and prevent the payment of services provided to people who are not eligible for universal plans.

At present, the information relating to a user, the care and services he has received or will receive, is scattered throughout as many files as there are establishments and professionals involved. A number of users even have to undergo the same examinations and retake the same tests because they are sent from one establishment to another. Sometimes a doctor prescribes medication to a patient without knowing that he is already being treated by another physician.

The multiplication of acts stems also from the fact that many examinations and analyses are designed solely to protect the doctor in the case of a lawsuit.

Moreover, a number of factors limit the possibilities of gathering information that would make it possible to exercise greater control over the numbers of acts. The identification of users having undergone a treatment is not always required by the RAMQ; this is particularly the case for certain medical specialities paid for by the act or by the unit and for physicians paid fixed fees such as a salary and vacation. This means the information needed to prevent the multiplication of acts which results from referring patients or physicians from private practices to establishments and from one establishment to another.

In addition, remuneration by the act or by the unit appears particularly poorly adapted to the exercise in establishments of certain

medical specialities whose intervention fits in with a course of treatment already in progress, at the request of the attending physician.

Finally, people who do not reside in Québec have had access to the universal health insurance plan by fraudulent use of the health insurance card.

To avoid this practice, the Minister intends to:

- **require users to be identified for the billing of services provided by radiologists, anatomopathologists, microbiologists, medical biochemists, nuclear medicine specialists and hematologists, as well as for all electrocardiograms and electroencephalograms;**

- **favour the use of electronic billing of these medical services to the RAMQ;**

- **require an activity report for any physician paid on a fixed fee basis;**

- **create a committee made up of representatives of medical federations, the Corporation professionnelle des médecins du Québec, associations of establishments concerned and the Ministry of Health and Social Services to study the relevance and feasibility of setting one of the following:**

  - **a compensation fund for damages sustained by users, as a result of using medical and hospital services;**

  - **a liability insurance plan for physicians, entirely financed by the government;**

- **evaluate the results of the experiment in progress regarding the use of electronic card with an integrated microprocessor and, if applicable, generalize its use by applying it to the health insurance card.**

This "health card" stores in its memory information on the health condition of the user, the services he uses or those he needs. This information is forwarded from one professional to another directly by the beneficiary, who keeps this card. In addition to being an essential follow-up tool, the health card will contribute to reducing multiple or needless repetition of tests, examinations or prescriptions.

The Commission d'accès à l'information has contributed to the work in progress to ensure that the possible introduction of this card safeguard the user against any breach of confidentiality on the data thus kept on record.

To prevent non-eligible individuals from taking advantage of the Québec system, the Minister intends to:

- **prevent health establishments and professionals from using a health insurance card with an expired date;**

- **ask the RAMQ, before issuing or renewing a health insurance card, to confirm that individual is eligible for the Québec system;**

- **ask the RAMQ to issue a health insurance card with a photograph of the cardholder and his signature.**

4.1.9 Prohibiting double remuneration of medical staff

Establishments seeking services of physicians have been known to grant the latter remuneration or other monetary benefits in addition to the fees they receive from the RAMQ. Although not generalized, this practice is more widespread than commonly believed.

To impress upon the establishments concerned that these practices are prohibited, the Minister intends to:

- **cut the budgets of deliquent establishments by an amount equivalent to that paid to the physicians concerned;**

- **suspend payment to these establishments of appropriations earmarked for technological development;**

- **have the RAMQ reduce the fees payable to the physicians concerned by an amount equivalent to the amounts obtained from the establishments.**

4.1.10 Rationalizing public and private laboratory operations

Individuals undergoing examinations or screening tests are entitled to know that such tests are justified. Furthermore, the results of such tests must be completely reliable. Consequently, the physician's prescription must contain precise indications. Downstream, the laboratory must meet recognized quality standards.

The incidence of tests and examination has been on the increase in recent years, for several reasons: the propensity to rely more heavily on results obtained by technological means than on the clinical examination; the development of technology; the increase of multiple pathologies among the elderly; the scarcity of regulations concerning care and use of resources for physicians; remuneration by the act.

The quality control of laboratory analysis is deficient. Public establishments have no specific permit to operate a laboratory. They are free to abide by certain mechanisms whereby the competence and quality of analysis are controlled. Laboratories that do so are not obliged to give further consideration to the conclusions of these evaluations. In radiology, many neglect to observe the safety rules required by the *Public Health Protection Act*.

Private laboratories are invited to submit to quality controls so as to obtain their permits; test centres circumvent this obligation, as they are not covered by any legislation.

In biochemistry, the Société québécoise de biochimie clinique offers a quality control service. In microbiology, the Laboratoire de santé publique du Québec (LSPQ) does the same, but free of charge. In anatomopathology and hematology, quality control remains a process internal to the medical profession. In medical imaging, some physicists are dealing with radiation protection.

To rationalize laboratory operations, the Minister intends to:

- **require any laboratory, whether it be publicly or privately run, to undergo external quality checks;**

- **entrust the Laboratoire de santé publique du Québec with the mandate to:**

  . **prepare and implement a quality control system for medical biology laboratories;**

  . **make recommendations to medical biology laboratories on improvements to be made;**

  . **submit a report to the Minister on situations presenting serious or chronic departure from the decreed standards;**

  . **issue an operating permit for private laboratories, which will attest to the laboratory's consent to submit to quality controls, particularly with regard to the quality of results;**

- **petition the Corporation professionnelle des médecins du Québec to establish rules for its members regarding prescription of laboratory examinations.**

4.2 Citizens who must assume the cost of services

The gratuity of services is an illusion. Citizens pay for the services they use. However, methods of payment vary widely, depending on whether payment is settled by the individual or the community.

For the past 20 years, Québec has prioritized collective financing, which is socially more equitable. Today the Government wants to continue in this vein, as do most consumers. But to reach its budget objectives, the government of Québec must find additional revenues in the short term while at the same time preserving the principle of equity, as it is forced to compensate for the financial withdrawal of the federal government. In the middle term, it will rely on the impact of efficiency measures, so that citizens may derive best possible benefits from their network of services.

To obtain these additional revenues, the government intends to:

- **institute a services tax on supplementary drug insurance programs, dental care, eye care, and orthotic and prosthetis services, based on the following terms and conditions:**

  . **addition to taxable income of the cost of services obtained over the previous year;**

  . **application of a tax to the cost of services received;**

  . **limiting of the amount thus collected to a percentage, to be determined, of the taxable income of the individual taxpayer.**

This approach will make it possible to maintain services free of charge for people who have no taxable income, i.e. welfare recipients and the elderly who receive the maximum guaranteed income supplement. For others, the contribution will be based on income and services received, without exceeding 2% or 3% of the taxable income.

This services tax should bring in approximately $100 million a year. The results of this effort would have been better distributed had it been possible to extract

this amount from basic programs rather than from supplementary programs designed for specific clienteles.

However, the *Canadian Health Act* forbids such a tax to be applied to medical and hospital services under penalty of a reduction of federal transfers equivalent to the amounts collected by virtue of this tax. The Minister will request that the federal legislation be amended.

It should be noted that even by applying this tax on services, Québec remains a leader when it comes to coverage of supplementary programs in Canada. No other province systematically takes into account the taxpayer's ability to pay, and certain provinces impose no limit on the contribution payable.

The citizen must also become aware of the costs of health and social services of all nature that he receives. This awareness is aimed at correcting the illusion of gratuity and, at the same time increasing the awareness of the cost and value of the services received. This is why the Minister intends to:

- **have the user countersign the billing slips used by professionals in private practice for reimbursement of their RAMQ fees;**

- **send all citizens a cumulative annual report on the type and cost of services received during the previous year either by a professional in private practice or in network establishments.**

CONCLUSION

Quebecers have repeatedly expressed their satisfaction with the health and social services system. Instituted barely 20 years ago, it has been responsible for an appreciable improvement in the health and well-being of the Québec population. Its implementation has been characterized by a removal of financial barriers, with the result that all citizens, without distinction, have had access to quality services. Over the past two decades, all agree that Québec has acquired an equitable system of services, at a cost considered relatively reasonable by the community.

Nonetheless, our system must contend with various difficulties. As far as financing is concerned, the question of efficiency of the services has become pressing, and major corrective measures seem necessary to reconcile the interests of the citizen as consumer with those of the citizen as payer. Perhaps even more pressing is the need to direct efforts towards an increased adaptation capacity, while at the same time maintaining the principal characteristics of the system. It is in this context that the major changes the government has made to the architecture and general operating rules in the health and social services network must be viewed.

These changes, in the main, are perfectly in keeping with major international trends in matters of health and welfare. Several OECD countries are taking a fresh look at their health and social services system. Those who have completed this analysis tend to prioritize the following objectives:

- **placing the citizen at the centre of the system;**
- **managing the system so as to find solutions to health and welfare problems;**
- **proceeding with decentralizing certain responsibilities and functions at both the regional and local level;**
- **relying on the contribution of other sectors of activity which have an impact on health and welfare;**
- **ensuring that the resources invested are used efficiently and that citizens get value for their money.**

The reform to the health and social services is relying on these objectives, to ensure that the users, which is to say the citizens of Québec, will have access to better services, and an even more performance-oriented health and social services system.

MAKEUP OF THE BOARDS OF DIRECTORS

CATEGORY OF MEMBER	MEANS OF DESIGNATION	CLSC	HOSPITALS, RESIDENTIAL AND EXTENDED CARE CENTRES HAVING MORE THAN 50 GENERAL AND SPECIAL CARE BEDS	RESIDENTIAL AND EXTENDED CARE CENTRES	CHILD AND YOUTH PROTECTION CENTRES AND REHABILITATION CENTRES FOR YOUNG PEOPLE OR YOUNG MOTHERS WITH ADAPTATION PROBLEMS	REHABILITATION CENTRES
Public representatives	Election during annual meeting	5	4	4	4	4
Staff	Designation by staff	3	3	3	3	3
User committes	Appointment (of a member solely in the case of hospitals having more than 10% of extended care beds)	-	2	2	2	2
Owner corporation (if applicable)	Appointment	-	3	3	3	3
Foundation (if applicable)	Appointment	1	1	1	1	1
University milieu	Appointment of one teaching representative and one research representative	(2)	(2)	(2)	(2)	(2)
School milieu	Appointment	-	-	-	1	(1)
Justice milieu	Appointment	-	-	-	1	-
Coopted members	Coopting	2	2	2	2	2
Executive director	Member ex officio	1	1	1	1	1
TOTAL MAXIMUM		12	16	16	18	16

ANNEX 1

MAKEUP OF THE REGIONAL ASSEMBLIES

REGION	ELECTED REPRESENTATIVES (20 %)	SOCIO-ECONOMIC GROUPS (20 %)	PUBLIC/USERS ESTAB. (40%)	B.D. MEMBERS COMM. ORG. (20%)	TOTAL (100 %)
01 Bas St-Laurent	16	16	32	16	80
02 Saguenay-Lac St-Jean	14	14	28	14	70
03 Québec	24	24	48	24	120
04 Mauricie-Bois Francs	20	20	40	20	100
05 Estrie	14	14	28	14	70
06 Montréal-métro	30	30	60	30	150
07 Outaouais	18	18	36	18	90
08 Abitibi-Témiscamingue	12	12	24	12	60
09 Côte-Nord	12	12	24	12	60
10 Grand-Nord (1)	—	—	—	—	—
11 Gaspésie-Îles de la Madeleine	12	12	24	12	60
12 Chaudière-Appalaches	22	22	44	22	110
13 Laval	12	12	24	12	60
14 Lanaudière	12	12	24	12	60
15 Laurentides	16	16	32	16	80
16 Montérégie	30	30	60	30	150

(1) To be determined with the Cree and Inuit

ANNEX 2 - A

MAKEUP OF THE REGIONAL ASSEMBLIES

# REGION (PUBLIC)	ELECTED REPRESENTATIVES	TOTAL
01 Bas St-Laurent (210,834)	2 per RCM x 8 RCM (etc.)	16
02 Saguenay-Lac St-Jean (285,457)	• Saguenay: 6 RCM Fjord du Saguenay: 6 • Lac St-Jean: 2 per RCM x 3 RCM: 6 + 2 Chapais, Chibougamau: 8	14
03 Québec (586,306)	2 per RCM x 6 RCM: 12 + 12 QUC (Québec City Urban Community):	24
04 Mauricie-Bois Francs (453,813)	2 per RCM x 10 RCM:	20
05 Estrie (257,755)	2 per RCM x 7 RCM:	14
06 Montréal-métro (1,752,582)	30 MUC (Montréal Urban Community):	30
07 Outaouais (256,795)	3 per RCM x 3 RCM: 9 + 9 ORC (Outaouais Regional Community):	18
08 Abitibi-Témiscamingue (146,770)	2 per RCM x 5 RCM: 10 + 2: James Bay, Lebel, Matagami:	12
09 Côte-Nord (104,598)	2 per RCM x 5 RCM: 10 + 2: Lower North Shore Municipality:	12
10 Grand-Nord (36,112)	To be determined	
11 Gaspésie-Iles de la Madeleine (112,455)	2 per RCM x 6 RCM:	12
12 Chaudière-Appalaches (356,768)	2 per RCM x 11 RCM:	22
13 Laval (284,164)	12 per RCM x 1 RCM:	12
14 Lanaudière (279,014)	2 per RCM x 6 RCM:	12
15 Laurentides (320,701)	2 per RCM x 8 RCM:	16
16 Montérégie (1,096,282)	2 per RCM x 15 RCM:	30

ANNEX 2 - B